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ABSTRACT

This document attempts to compile information on best practices for many of the core services of school-based programs for pregnant and parenting teens and their children. It includes an overview of standards and guidelines that have been substantiated by either research or professionals in the field. These guidelines are intended to help communities build comprehensive, effective programs for young families. Specific guidelines are provided for the following areas: (1) child care; (2) prenatal care and reproductive health care for children; (3) preventive health care for children; (4) parenting education; (5) case management/family support; (6) flexible, quality educational programming; and (7) father involvement. For each service area there is an introduction, the guideline area in boldface, the proposed guideline or standard for best practice, and bullet statements that support or justify the guideline. Forty resource organizations and 13 resource publications are listed. (Contains 153 references.) (SLD)

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# SCHOOL-BASED PROGRAMS FOR ADOLESCENT PARENTS AND THEIR YOUNG CHILDREN

## GUIDELINES FOR QUALITY AND BEST PRACTICE

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# School-Based Programs for Adolescent Parents and Their Young Children

## Guidelines for Quality and Best Practice

October 1996

Susan T. Batten
Bonita G. Stowell

Center for Assessment and Policy Development

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S.T.B.
B.G.S.

# INTRODUCTION

## Background

School-based programs for pregnant and parenting teens and their children offer many advantages. Most important, they have the potential to improve critical outcomes for teens and their children by connecting young parents to a comprehensive array of services before they drop out of school and become alienated from the educational system. Identifying and serving teen parents before they drop out is critically important; research suggests that non-school interventions with adolescent parents who have already dropped out have only modest effects on increasing social and economic self-sufficiency (Long et al., 1996), while there is new evidence that intervening before they drop out is more effective. School-based services for the children of teens are as important. Almost half of all poor children in this nation are born to an adolescent parent; this population of children is at greater risk of poor health and developmental outcomes. Well-designed school-based services for adolescent parents offer opportunities to link these children to necessary basic preventive health and child development services.

There is consensus among professionals in the field about the types of services that are critical to school-based efforts to facilitate the long-term self-sufficiency of young parents, build their parenting capacity and ensure the healthy growth and development of their children. These core services, which can be provided by schools or in partnership with others in the community, include:

- flexible, quality schooling to help young parents complete high school or obtain their GED;
- case management and family support services;
- access to prenatal care and reproductive health services;
- parenting and life skills education and supportive services; and
- quality child care for their children with links to basic preventive health care.

Many school districts across the country have instituted programs that include these critical elements. The Center for Assessment and Policy Development's School-Based Initiative for Adolescent Parents and Their Young Children, after an extensive review of model school-based programs across the country, is currently working with three communities (Portland, Ore., Minneapolis and Pittsburgh) to expand the scope and scale of these services for young families. However, the ultimate effect that these programs have on the population of interest greatly depends on the quality and supply of these necessary program components. As such, schools and communities must periodically assess the extent to which their efforts include strategies that have been proven to make a difference.

This document attempts to compile information on best practices for many of the core services listed above. It includes an overview of standards and guidelines that have been substantiated by either research or professionals in the field. Providing comprehensive services to young families requires partnerships between many stakeholders including schools, health and social service providers and child care providers. Often, these organizations bring different philosophies, experiences and knowledge to the table. We hope that this document may begin to increase awareness about best practices across fields to ensure a well-functioning system of supports for adolescent parents and their children.

Garnering Support for School-Based Teen Parent Programs

Teen parents, and providing services to support them, are often controversial topics. Whether communities are interested in starting new school-linked services for this population, or strengthening existing efforts, educational staff and other service providers helping this population are bound to encounter resistance. For these reasons, programs should consider strategies that may assist in garnering ongoing support from key stakeholders, including high-level educational and community officials. These may include:

- the development and maintenance of a broad-based advisory committee.

  Many teen parent programs across the country were developed by the coming together of various advocates for this population, including school, health, youth service and child care officials. Not only are such groups helpful in developing comprehensive services for young families, they become supportive voices for this population that, when united, are a formidable force for the support of teen parents and their children.

- describing efforts to support teen parents in ways that encompass other community agendas.

  Efforts should be made to help the larger community understand how teen parent programs address other pressing community problems. For instance, these efforts aim to prevent school drop out, teen pregnancy and welfare dependency. In addition, programs serving teen parents and their children seek to promote positive youth development, sex equity in schools and school readiness among the children of adolescents. In efforts to build support for them, service providers must help naysayers understand the multiple benefits of these programs.

- the use of data to illustrate program need and benefits.

  It is difficult to argue against fact. Many programs have been successful in winning the support of key stakeholders by educating them on the need for

school-based teen parent programs and their potential impacts. This requires programs to have the capacity to gather, analyze and report on data regarding pregnant and parenting teens and their children. Often, when dialogue about serving young families becomes emotional and controversial, the best strategy is to rely on rational and factual information about program needs and benefits.

The Common Denominator: Providing Accessible Teen Parent and Child-Normed Services

While young families can benefit from various types of supports, there are several common issues that all practitioners must address regardless of the goals, focus and desired outcomes of their particular service. These cross-program issues are further discussed below.

- Providing accessible services to all teen parents.

  The advantage of providing school-based and/or linked services is to facilitate the receipt of beneficial supports that do not interfere with a teen's participation in school. Service accessibility requires joint, continuous planning between educational and other service systems to ensure that adolescent parents successfully graduate from school and/or obtain their GED.

  Service providers must also take steps to ensure that programs are accessible to teen fathers as well. Often, well-meaning programs unknowingly send messages that suggest males are not welcome. Teen fathers need access to all of the services and supports provided to teen mothers. As such, the services and the quality guidelines described in this document apply to serving both parents. However, this paper does include a section specific to serving teen fathers. This is included to provide further information on emerging strategies and approaches for supporting young fathers.

- Using staff familiar with and sensitive to the needs of teen parents.

  Adolescence is a dynamic stage of human development. During this time in their lives, teens are among other things, striving for independence, seeking peer acceptance and formulating their sexual identify. Coupling these major life transitions with issues that affect most teen parents (i.e., poverty, school failure, etc.) requires that staff working with this population have the necessary skills and attitudes to improve teens' life choices. In addition to their parents, the children of teens have special needs and require services that are tailored to these issues as well. Programs serving this population must invest in the development of staff to increase the likelihood that services are teen-normed, relevant to life experiences, age-appropriate and take into consideration the populations's special needs so that the programs may achieve desired results.

- Providing culturally relevant services.

  The cornerstone of helpful exchanges between practitioner and client is a trusting relationship based on mutual respect. Building on an individual's strengths helps develop such relationships. Regardless of focus, programs serving young families should acknowledge and affirm their cultural identity, values and beliefs to increase the potential for success.

While this document provides detailed guidelines for quality and best practice across key services, these three issues are common to all.

How to Use This Document

It is our hope that these guidelines help communities build comprehensive, effective programs for young families. More specifically, this document may be used to:

- assess current teen parent services by determining the extent to which existing program components adhere to these guidelines;
- strengthen existing services by modifying those that do not meet these guidelines;
- educate staff and other advocates working with and/or on behalf of teen parents and their children about the necessary resources and costs to provide quality services; and
- facilitate discussion and consensus among partnering education, health, social service and child care organizations on desired community-wide policies and practices for supporting teen parents and their children.

Over time, as the field advances in its thinking about standards that affect program quality, these guidelines may become somewhat dated. For this reason, we do not expect this guide to be the ultimate source of information on quality programming for teen parents and their children (it is important to point out the resources listed in the back of this document that provide guidance on programs serving young families). Readers should continue to look beyond this document when assessing, strengthening and/or expanding services for this population.

The remainder of this document provides guidelines in the following areas:

- child care;
- prenatal care and reproductive health services;

- preventive health care for children;
- parenting education;
- case management/family support;
- flexible, quality educational programming; and
- father involvement.

For each service area, there is an introduction, the guideline area in boldface (i.e., service area is child care; guideline area is **staff/child ratio**), the proposed guideline or standard for best practice, followed by bullet statements that support and/or justify the guideline.

## I. CHILD CARE

*Child care is a critical service which must be provided if we are to help move young parents toward independence and help their vulnerable children overcome the barriers that face them. (Edelman, 1987, from Cahill et al., 1987)*

School districts have several options for linking children of teen parents to quality child development programming. Many have developed on-site centers that offer convenience for the parent and allow school-based staff to monitor the child's growth and development. Others have developed family child care homes around schools that offer a unique environment for infants. Regardless of the type of care provided, particular attention needs to be paid to factors that enhance the quality of these programs for infants and toddlers, including their size, structure, environment and background of caring professionals. These issues are discussed below, first for center-based care and then family child care.

While the guidelines below are provided to facilitate quality programming in early childhood programs, services providers, at a minimum, must meet individual state licensing requirements in these areas (i.e., staff/child ratio; staff training, etc.).

### A. Center-Based Care

#### Group Size

Groups within center-based care should be developed according to the age of the children. Acceptable group sizes for centers range from 6 to 8 for infants; 6 to 12 for toddlers, and 16 to 20 for preschoolers.

- Research suggests that the total number of children in a group affects the interaction between the child and caregiver and among peers, which in turn affects child development. In center care settings, larger groups have been associated with both less positive interaction patterns (Howes, 1983; Howes and Rubenstein, 1985) and development outcomes (Holloway and Reichhart-Erickson, 1988; Clarke-Stewart, 1987; Kontos and Fiene, 1987).

- Ranges described above (Hayes et al., 1990) were developed from the National Association for the Education of Young Children (NAEYC), National Black Child Development Institutue (NBCDI) and Child Welfare League of America (CWLA) positions.

#### Staff/Child Ratio

Child care programs should be adequately staffed to facilitate healthy child development. Acceptable staff/child ratios for center-based care are 1:4 for infants; 1:3 to 1:6 for toddlers; and 1:7 to 1:10 for preschoolers.

- Research indicates that smaller staff/child ratios in center-based care are particularly important for infants and toddlers. Caregivers are better able to facilitate positive social interactions and to foster a more positive emotional climate. Lower ratios are found to be associated with a higher incidence of secure attachment to caregivers by toddlers. In several studies, children in groups with more children per adult engaged in significantly less talk and play behavior (Howes, 1983; Howes et al., 1988; Howes et al., 1985).

- Ranges described above (Hayes et al., 1990) were developed from NAEYC, NBCDI, CWLA positions.

**Staff Training/Education**

Child care professionals should receive training in the field of early childhood development. Professionals who care for children of teen parents would benefit from training on the special needs of adolescent parents and their children as well.

- Research indicates the importance of both caregiver training specific to child development and overall caregiver education for positive child care outcomes. However, two existing national studies point to caregiver training as the more important factor (Hayes et al., 1990; NDCS, 1979; NDCHS, 1981).

- More recent research suggests that specialized training in early childhood (i.e., higher than a CDA), is more positively associated with quality (Cost, Quality and Child Outcomes Study Team, 1995).

- The length of a center administrator's experience has also been associated with quality (Cost, Quality and Child Outcomes Study Team, 1995).

- There is emerging professional opinion that caregivers of children of teen parents would benefit from training on the special needs of adolescent parents and their children. Many professionals agree that caregivers can support young parents and help them develop sound childrearing behaviors and also may ensure that their children, who are at risk of poor physical, emotional and intellectual growth, are linked to basic screening and preventive services (interviews with Burroughs, 1994; Monroe, 1995).

**Caregiver Stability and Continuity**

Efforts should be made to ensure that children do not experience frequent changes in caregivers and/or programs. Children in child care centers should be assigned a primary caregiver to further assure that enduring child/adult relationships are developed.

- Research points to the importance of children's needs for enduring relationships with particular caregivers. The number of changes a child experiences in child care arrangements has implications for both short- and long-term development. Multiple arrangements have been found to be associated with higher rates of insecure attachment to mother (Vaughn et al., 1980; Suwalsky et al., 1986). Stable care was also found to be related to positive longer term development; greater early stability predicted better school adjustment in the first grade (Howes, 1988).

- Infants and toddlers were found to be less distressed when transferred from mother to a more familiar, as opposed to a less familiar, caregiver upon arrival at a child care center (Cummings, 1980). Toddlers in a child care center with a highly involved caregiver were found to more freely explore an unfamiliar room and more often made physical and visual or vocal contact with the caregiver (these are behaviors suggestive of secure attachment) (Anderson et al., 1981).

**Daily Routine/Curriculum**

Early childhood programs should include some daily learning activities in order to facilitate cognitive development. Learning activities should be both caregiver- and child-initiated. In addition, early childhood programs should include some unstructured time for group interaction and play.

- The daily amount of free play time in child care has been associated with predicted less advanced language development for children; however, the amount of group activity time positively predicted language development (McCartney, 1984). More positive cognitive measures have been associated with more teacher-managed than open-ended activities in child care (Ruopp et al., 1979).

- A variety of curricula are equally effective in preparing children for school; one study suggests that any curricula is better than no program at all (Royce et al., 1983). Diverse curriculum models can be equally effective in improving children's education (Schweinhart et al., 1986).

- Children in teacher-directed preschool programs demonstrated less adequate social adaptation than groups of children in programs that relied more on child-initiated and self-paced learning activities in environments prepared for by teachers (Schweinhart et al., 1986). Further research on learning processes points to the need for curricula to allow for individual differences in learning styles and the importance of learning through interactions (Greenfield and Lave, 1982).

**Parent/Family Involvement**

Parents, as well as other family members or primary caregivers, should be encouraged to be involved in child care programs. Involvement can take on many forms, ranging from participation in special family activities to participation in advisory councils and/or committees that oversee the administration of child care programs, involvement in the classroom and involvement in home activities with their children. Male involvement, as a way to facilitate positive experiences between men and children, is also critically important. However, special efforts may be needed to make child care programs male or "father friendly."

- Research, generally on older children, suggests the effectiveness of parent-teacher collaboration on student development and performance (Cummins, 1986). However, effects of parent involvement in child care on the development of young children has not been rigorously evaluated.

- Many professional organizations stress the importance of parent involvement in the child care setting (NAEYC, NBCDI, CWLA).

- Teen parent involvement in the child care setting provides an opportunity for caregivers to model sound childrearing practices (feeding, changing diapers, supervised play, etc.)

- Boys and girls with involved and nurturing fathers tend to be better adjusted than those without (Levine, Murphy, Wilson, 1993).

**Cultural Relevance**

Early childhood programs can facilitate positive cultural identification and affirmation and, ultimately, development. Efforts should be made to incorporate positive images of cultural groups in early childhood programs, including materials and educational activities. Programs should build on the values of diverse families and on the child rearing practices, learning styles and language used in the home. One way to do this is to hire staff of similar cultures or from the communities in which children live. In addition, staff would benefit from training in working with parents in culturally sensitive ways.

- Research on multicultural approaches in child care and its affect on child development has been sparse to date. However, research with older children suggests that multicultural approaches may be important to a child's cognitive development and positive adaptation (Cummins, 1986).

- There are numerous indications that processes of cultural group identification begin early; many young children from minority groups form negative views of their cultural group (Aboud, 1988; Comer, 1989; Spencer 1985).

- Children with positive group identity show greater resilience to psychological stress (Spencer, 1988).

- Programs that understand, acknowledge and build upon the socialization from family and community have been much more successful in improving intellectual, cognitive and social outcomes for minority children (Chang and Sakai, 1993).

- To strengthen their emerging sense of self and connection with their families, infants and toddlers from non-dominant groups need plenty of opportunities for positive interactions with members of their culture (Far West Labs).

- Child care programs that do not use home language contribute to the demise of a young child's ability to speak the language of his/her family, and diminish vehicles for age-appropriate concept development and socialization (Wong, 1991; Siren, 1991; Harrison and Piette, 1981).

- Considerable research data suggest that, for dominated minorities, the extent to which students' language and culture are incorporated in the school program constitutes a significant predictor of academic success (Cummins, 1986).

- Several professional organizations support the affirmation of cultural diversity (NAEYC, NBCDI).

**Layout and Design**

Child care facilities should be designed to enhance safe learning and play experiences for young children. As such, they should be spacious and well equipped with child-designed materials, and should have well-differentiated areas for different activities (i.e., play and rest) as well as for different age groups.

- While limited research has been conducted in this area, some studies suggest that children demonstrated better cognitive and social skills in centers that were more orderly, that had more varied and stimulating materials, and in which space was organized into activity areas (Clarke-Stewart, 1987).

### Nutrition, Health and Safety Practices

Quality child care programs should employ good health, nutrition and safety practices that promote good health and reduce the risk of injury and the spread of communicable diseases.

- Extensive work has shown that malnutrition may impair cognitive performance (Nagel, Worobery, 1993; Espinosa, 1993). Child care programs offer opportunities to ensure that children receive a variety of nutritious foods and are taught good dietary habits.

- Health precautions include not only protection from the spread of illnesses, but also care in food preparation, and cleanliness in sleeping and play areas. Staff should ensure the frequent washing of rattles and toys known to be used for teething, as well as diapering tables and areas (Cataldo, 1983).

- Existing scientific evidence and best professional practice from the fields of pediatrics and public health suggest a number of practices for safeguarding the health and safety of children in child care settings, including: limiting group size; separating groups of children according to age; strictly adhering to hand-washing practices, particularly after diapering and before food preparation; regularly cleaning and disinfecting diaper changing surfaces and communal objects and toys; excluding children with bloody stool and children younger than age two with fever, as well as other selected infectious diseases; rifampin therapy following the identification of an index case of Hib meningitis; and immunoglobluin prophylaxis following identification of an index case of viral hepatitis (Hayes et al., 1990).

### Professional Accreditation

To the extent possible, child care programs should seek professional accreditation. Efforts to do so are typically associated with providing quality care.

- Voluntary conformity to higher standards through professional center accreditation (i.e., NAEYC) has been associated with high quality care (Cost, Quality & Outcomes Study Team, 1995).

## B. Family Child Care

Quality issues discussed for center-based care apply for family child care as well. Differences along specific indicators (such as group size), as well as dimensions of quality specific to family child care are discussed here.

**Staff/Child Ratio**

As in center-based care, staff/child ratio is an important indicator of quality programming. In family child care, staff/child ratio is usually synonymous with group size. Acceptable staff/child ratios for mixed age groups in family child care are 1:4 to 1:6, including the providers' own children, with no more than two children under the age of two.

- The ranges described above are derived from the Children's Foundation, the American Academy of Pediatrics, the American Public Health Association and Far West Laboratories positions on appropriate ratios in family child care.

**Supports Provided to Family Child Care Providers**

Family child care providers should receive support in their efforts to provide quality care. These supports may come in many forms, including professional training, networking activities in which caregivers can share lessons and experiences with each other, and arrangements to share materials and equipment with providers.

- Emerging research on factors of quality family child care suggests that being a part of a network of providers helps reduce isolation in the working environment. In addition, the frequency of individual supervision and training that a family child care provider receives affects the quality of caregiver-child interactions (Hayes et al., 1990; NDCHS, 1981; Rosenthal, 1988).

- New research on family child care suggests that various training formats, including differences in the intensity of training, can be effective in improving child care quality. However, more study is needed to determine the most effective training methods for family child care providers (Galinsky et al., 1995).

**Regulatory Status**

To the extent possible, children should be cared for in legal family child care arrangements. Requirements for licenses, registration and/or certification will vary from state to state; however, efforts should be made to place children in homes that meet minimum quality and safety standards.

- Regulatory status in family child care has been associated with quality. Caregivers in unregulated homes have been found to spend less time engaged in meaningful child interactions than regulated providers (NDCHS Fosburg, 1981).

## II. PRENATAL CARE AND REPRODUCTIVE HEALTH SERVICES

*Infants born to adolescent mothers are at greater risk than infants born to older mothers...despite the importance of prenatal care, adolescents often initiate prenatal care later than older women. (Daykin et al., 1994)*

*The importance of family planning services in reducing unwanted first or subsequent births to adolescents cannot be understated. Research estimates show that the rate of unintended pregnancy could fall 35 percent among whites and 63 percent among African Americans, given current technology and universal use of contraceptives. (Miller and Moore, 1990)*

Access to prenatal care and reproductive health services, namely family planning, are critical to preventing poor birth outcomes for teens and additional, unplanned pregnancies. Staff involved with pregnant and parenting teens must facilitate access to these services (not necessarily administer them) and, to the extent possible, ensure that they are provided in a timely manner and incorporate strategies that address particular issues related to adolescent pregnancy and parenting.

### Schedule for Prenatal Visits

Pregnant adolescents should receive prenatal care as early as possible in the pregnancy, and subsequent visits should be made frequently. For the first 28 weeks, visits should occur every 4 weeks, every 2 to 3 weeks from the 29th week until the 36th week of gestation, and weekly from the 37th week of gestation until birth.

- This schedule for prenatal visits is endorsed by the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP) and CWLA.

### Core Services to Address Needs of Pregnant Adolescents

Prenatal programs should be linked to specific services for adolescent mothers, including: nutritional guidance; drug, smoking and alcohol counseling; generic counseling to address stress related to teenage pregnancy; and treatment of health problems that occur during pregnancy. In addition, steps should be taken to ensure that prenatal care services are accessible — this may require transportation and child care assistance.

- Teenagers are at higher risk of adverse pregnancy outcomes (including low birthweight) because of various factors, including the physiological characteristics of young women and lower sociodemographic status (Peterson and Brindis, 1995).

- Factors such as poor nutrition habits, smoking, drinking and drug use among teenagers all pose the danger of long-term health and developmental problems (Daykin et al., 1994; Wymelenberg, 1990).

- Adolescents suffer disproportionately from certain medical conditions associated with pregnancy: toxemia, anemia, renal conditions, prolonged labor or premature labor (Daykin et al., 1994; Combs-Orme, 1993).

- Adolescents may delay prenatal care for a number of reasons, including denial or concealment of pregnancy, indecision about how to resolve the pregnancy, inconvenience of clinic hours, lack of transportation, or fear of medical tests and procedures or unavailability of services. Prenatal care programs specifically designed to meet the needs of adolescents can reduce adverse outcomes for mothers and babies (Daykin et al., 1994; Combs-Orme, 1993).

- Research suggests that prenatal care services for young women may need to include: transportation to the prenatal clinic and child care for the young mom's other children while she is there; a wide array of follow-up services (including instruction in better nutrition); home visiting and outreach to encourage the first prenatal visit; and a staff person who takes the time to listen to the young mom's needs and works with her to meet them (Schorr, 1991).

**Father Involvement in Prenatal Care**

Programs for pregnant and parenting teens should make efforts to include fathers in prenatal care services. Not only may this facilitate strong relationships between men and their children; it may also influence the mother's use of critical prenatal services.

- A study of unwed teen parents in Boston indicates that getting fathers to participate with mothers in prenatal activities and delivery increased the likelihood they will help after their babies are born. The study suggests that active participation in the pregnancy may help these men formulate their roles and responsibilities as fathers. Therefore, programs encouraging unwed fathers to join in prenatal activities and delivery might increase their long-term commitment to the family (Cox and Bithoney, 1995; Children and Youth Funding Report, 1995).

- Research conducted by the Missouri Department of Health indicates that the use of available prenatal care is significantly related to help and support from the baby's father. While others close to the mother influence her use of prenatal services, none prove to be as significant as the man who is the baby's father or the mother's current male partner (Sable, Stockbauer, Scramm and Land, 1990).

- Through its work with teen fathers, staff at the Mount Sinai Medical Center's Teen Pregnancy Clinic have found that young fathers had a strong desire to be involved in their baby's life from very early on and were eager to be a part of their partner's pregnancy. Even though staff at the clinic did not encourage young fathers to attend prenatal visits, the fathers consistently attended appointments and were interested in hearing the heartbeat, attending the sonogram, and receiving information from the medical staff. Also, it was observed that the fathers were more helpful to their partners when they were included, when things were explained to them, and when they felt respected (Adams, 1995).

- A 1982 study found that the father's presence and aid at the birth directly reduces birth complications and further illness in the child and mother after delivery. The study concluded that father presence reduces the terror, loneliness, sensory deprivation, and confusion of labor, especially protracted labor, resulting in decreased birth complications (Richman, 1982; Pruett, 1996).

**Family Planning Education and Services**

Effective family planning services for adolescents (both males and females) should use a multi-pronged approach. Specifically, efforts to reduce repeat pregnancies should combine pregnancy prevention education, access to contraceptive services and programs to improve life options.

- Emphasizing abstinence or contraception alone is not sufficient for adolescents at risk of unintended pregnancy (Peterson and Brindis, 1995; Guttmacher Institute, 1994).

- Family life and sex education classes, and school-based health clinics offering contraceptive counseling or services have not been shown to increase sexual activity or hasten its initiation among teens (Kirby, 1994). Evaluations have demonstrated that some sex education programs can reduce unprotected intercourse, either by delaying the initiation of intercourse or by increasing the use of condoms and other contraceptives (Kirby, 1994; Peterson and Brindis, 1995).

- Teen education and information programs are important components of adolescent pregnancy prevention programs. However, research suggests that education that attempts to change sexual behavior, combined with access to contraceptives tailored to the needs of teens and programs to increase life options and provide meaningful alternatives to childbearing are more effective (Peterson and Brindis, 1995; Trussell, 1988; Edwards, 1991; Hughes, 1995; Allen, 1990).

- Teenage pregnancy prevention must be directed to boys as well as girls. Family planning education and services should be presented to boys and young men in a way that is non-judgmental, promotes a positive sense of belonging, and builds trust (Felix Gonzales, Director, Hispanic Male Outreach Program). Policymakers and program directors have a tendency to leave men out of the family planning equation — often because they forget gender dynamics, assume men will not take part, or take the attitude that boys are fundamentally irresponsible (Sachs, 1994; Levine and Pitt, 1995). As a result, men often are reluctant to go to gynecological, obstetric, or maternal clinics where staff assume that men are the enemy (Sander and Rosen, 1987). So policymakers and program directors must remember that boys and young men share equal responsibility for a pregnancy. If prevention is targeted only to girls, it is incomplete (Levine and Pitt, 1995).

**Strategies to Reduce Repeat Pregnancies**

Efforts to reduce repeat pregnancies should include intensive individual, personal and psychosocial counseling in addition to follow-up counseling about contraceptive choices, as well as peer group counseling, parent support groups, and case management services.

- Few programs have been able to effectively assist adolescent mothers to delay a subsequent pregnancy. Those that have been successful provide intensive individual counseling and services (Peterson and Brindis, 1995; Olds et al., 1988).

- Strategies that have proven effective in improving contraceptive use among sexually active adolescents and lowering pregnancy rates include comprehensive school-clinic programs, vigorous follow-up, and adaptation of the medical service delivery model to the psychosocial needs of adolescents (Daykin et al., 1994). Examples of how to tailor family planning services to the psychosocial needs of adolescents include modifying the clinic environment to alleviate young patients' fears and increase their sense of comfort with the clinic; providing long one-on-one educational sessions using visual aids; conducting staff training on the psychosocial needs of adolescents; breaking up clinic visits into an educational component followed at a later date by the medical exam; and conducting a follow-up medical exam six weeks after the initial one (Daykin et al., 1994). Experimental sites adapting these tailoring strategies show improved contraceptive use among adolescents within six months after the first visit, greater knowledge of contraceptive methods and options, and lower pregnancy rates (Winter and Breckenmaker, 1991).

## III. PREVENTIVE HEALTH CARE FOR CHILDREN

*All our nation's children deserve the attention, the encouragement, and the intervention of care providers from many disciplines to ensure that they develop the healthy bodies, minds, emotions, and attitudes to prepare them to be competent and contributing adults. (Morris Green, M.D., 1994)*

School-based programs for pregnant and parenting teens provide opportunities to link children of adolescents, a population often poor and at risk of poor health outcomes, to basic preventive health services. Quality preventive care includes immunizations, well-baby check-ups and developmental screens.

### Immunizations

All children should receive immunizations to guard against preventable diseases. The current recommended schedule for childhood immunizations is:

| | |
|---|---|
| Birth to 2 months | Hep B-1 |
| 2 months | DTP, Hib, OPV |
| 2 to 4 months | Hep B-2 |
| 4 months | DTP, Hib, OPV |
| 6 months | DTP, Hib |
| 6 to 18 months | Hep B-3, OPV |
| 12 to 15 months | Hib, MMR, |
| 12 to 18 months | DTP, VZV |
| 4-6 yrs. | DTP or DTaP, OPV, MMR |

- The above immunization schedule is recommended by the American Academy of Pediatrics (AAP), the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians (AAFP) as of August 1995 (the Varicella Zoster or VZV vaccine is recommended for children not previously vaccinated and who lack a reliable history of chicken pox). This schedule is reviewed annually and is subject to change.

- Immunizations are among the most cost effective preventive health care measures that can be provided to children. Every dollar spent on immunizations has been estimated to save between $10 and $14 in later medical care costs (U.S. Department of Health and Human Services, 1992).

### Well-Baby Check-Ups

Physical examinations or well-baby check-ups provide opportunities for physiological and behavioral observations that help identify strengths, issues, and potential risk factors for the child and family. Infants should receive a well-baby check-up once at birth, once 2 to 4 days after

birth (for newborns discharged in less than 48 hours after delivery), and at the 1st, 2nd, 4th, 6th, 9th, 12th, 15th, 18th, and 24th month of age. After 24 months, children should be given a well-child check up once a year, every year up to age 21.

- This schedule is recommended by AAP, the Maternal and Child Health Bureau, the National Center for Education in Maternal and Child Health, the U.S. Department of Health and Human Services, and the Committee on Practice and Ambulatory Medicine. How often children require health supervision by health professionals is based on the principles of child and family development (Green, 1994).

**Developmental Screening**

Infants and young children should undergo developmental assessments to identify the child's and family's abilities and resources, and the conditions most likely to facilitate the child's healthy growth and development. Assessment should be collaborative (involving professionals and parents together) and should be conducted by professionals who: understand child development; can work with young parents; and can compile information from multiple sources to develop credible assessments and plans for development. Developmental/behavioral screens should be conducted on the same schedule as well-baby check-ups.

- Guidelines for professionals are recommended by the ZERO TO THREE Work Group on Developmental Assessment, 1993 (Greenspan et al., 1993).

- The recommended timetable for developmental/behavioral screens is the same as the timetable for the well-baby check-ups (AAP, ACIP, and AAFP). However, research shows that a child's developmental timetable is highly dependent on individual factors. Not all children will develop at the same pace (Administration for Children, Youth and Families, 1995; Green, 1994).

**Lead Screening**

Lead exposure during childhood, even at low levels, affects the central nervous system in adverse ways that persist into young adulthood, resulting in higher rates of learning disability, low achievement and failure to graduate from high school (Needleman et al., 1990). Screenings should be conducted at least once between 6 months and 6 years of age.

- Recommendations above are by AAP and the Centers for Disease Control (CDC). For at-risk children (children in areas where lead poisoning is common for example), it is recommended that they receive at least one lead screening test between 9 and 12 months of age and a second test at 24 months of age. This recommendation is under review and debate.

## IV. PARENTING AND LIFE SKILLS EDUCATION

*Although some young mothers have experienced sufficient positive parenting to become good mothers, many have unrealistic expectations of what motherhood is like and little knowledge of child health and development. (Klerman & Horwitz, 1992)*

*It is commonly assumed that teenage or unwed fathers ... are irresponsible and uncaring. Yet research...shows instead that these men often care deeply for their children; but if they are unprepared for the responsibilities of fatherhood, they are likely to be highly stressed and much less able to fulfill those responsibilities. (Achatz and MacAllum, 1994; Belsky and Miller, 1995)*

One of the most important facets of comprehensive programs for pregnant and parenting teens are their efforts to build the parenting capacity of its participants. These include services that aim to empower young families to obtain resources they need for their children and themselves. Parent education classes and support groups are just two strategies for obtaining this goal. Curriculum, program delivery strategies and frequency of these services all affect the quality of these efforts. However, it is important to remember that all staff providing services to teen parents, including case managers, child care providers, school and non-school health providers and school counselors/advocates, play an integral role in modeling parenting skills and building parenting capacity.

### Curriculum

Parenting education curriculum for teen parents should be culturally and linguistically appropriate and should address child development (i.e., physical and mental developmental stages); infant care skills (i.e., feeding, bathing, clothing, diaper changing); healthy emotional development (i.e., consistently responding to infant needs, helping toddlers develop and use words for their feelings); child stimulation activities (i.e., issues related to play spaces, toys, out-of-doors play); toddler care skills (i.e., encouraging verbal development, "babyproofing," toilet training, television program monitoring); nutrition (i.e., prenatal nutrition, breast feeding, bottle feeding); and community resource awareness (i.e., emergency contacts, family planning, health and human services).

There are certain curriculum topics that should be highlighted or addressed repeatedly to adolescent parents — these include family planning, nutrition counseling, awareness of community resources, crisis or depression counseling, and life skills counseling.

- Curriculum components are a compilation of recommendations by the Academy for Educational Development, Parents As Teachers Program, and the Oregon Parenting Education/Child Development Program.

- In parenting education programs that focus on reducing repeat teen pregnancies, it is important to offer frequent opportunities for 1) young moms to discuss

matters related to family planning (such as satisfaction with birth control method or satisfaction with the health practitioner where her birth control services are obtained); and 2) for staff to reinforce the notion that the next baby should be deferred and planned (Cahill, White, Lowe, and Jacobs, 1987).

- Nutrition counseling for pregnant and parenting adolescents is particularly important in both pre- and postnatal stages. Adolescent pregnancies are more likely to have infant complications (low birth weight, birth defects) than adult pregnancies (Daykin, Eu, & Zimmerman, 1994). Research has shown that these problems can be linked to the inappropriate health behavior practices, and that nutrition counseling has proven to be effective in decreasing poor birth outcomes (CWLA Standards for Services for Pregnant Adolescents and Young Parents, 1986; Flinn Foundation, 1994; Legislative Budget and Finance Committee, 1994; Wymelenberg, 1990).

- Young parents often have less knowledge about available community resources for children than adult parents (interview with Bell, 1995). It is important that they become aware of how to access available resources if they are to learn how to function independently and become skilled problem-solvers. Therefore, programs should provide clear, in-depth reviews of how and where adolescent parents can access needed resources, and should help develop the skills of these young parents in their use of such resources (Parent/Infant Interaction Program).

- Crisis counseling is necessary because adolescent parents have high rates of depression — especially with second or subsequent pregnancies (Combs-Orme, 1993; Flinn Foundation Report, 1994).

- Understanding what it takes to become and stay emancipated (i.e., budgeting your money, balancing a checkbook, etc.) and life skills counseling or training are important components of parenting education for teen parents because they often do not know what is involved in becoming and maintaining financial independence for themselves and their children (interview with Tate, 1995).

- For teen fathers, the curriculum should include a component that prepares youth for responsible fatherhood. Establishing this component will require that parenting educators: 1) respect and reinforce the importance of the father's role; 2) teach the consequences of becoming a father and its impact on others (the mother, the baby, the community); and 3) let men know that if they become fathers, their community expects them to take their role seriously, not casually (Levine and Pitt, 1995).

- Programs for teen fathers should provide assistance and guidance in establishing paternity (interview with Simpson-Brown, 1996).

- The curriculum and activities should be sensitive to the adolescent parent's culture, religion, and economic status. What is appropriate to share with one group of adolescent parents may not be appropriate with another group (interviews with Siner, Tate, 1995; Daykin et al., 1994; Solomon and Liefeld, 1994).

- Programs should survey dads to see what questions or issues they have and build the fatherhood component of the curriculum around their needs. Most dads have feelings, opinions and some expertise when it comes to some of the topics. Drawing upon the resources among the dads themselves builds trust, and gets them to accept the parenting program by making them partners in the curriculum development process (Levine, Murphy, and Wilson, 1993).

**Strategies for Program Delivery**

Teen parenting education programs should include a mix of program and delivery strategies including a practicum or learn-by-doing teaching method, observation of parent/child interaction, peer support, recreational programming, and activities that include and support the adolescent parent's family. Working with fathers may call for using similar service delivery strategies. However, fathers parent differently from mothers (for example, fathers engage in more rigorous types of play with their children than mothers). As such, techniques for teaching parenting skills for men and women may be different and expectations about what successful parenting or parent/child relationships look like should be different.

- A practicum or learn-by-doing method of teaching allows the teacher to model behavior and ensures that the teen parent can relate the information he/she is learning to his/her own experience. Parenting education for teen parents is most effective when it is not provided solely through classroom techniques, but through less formal counseling, role modeling, peer counseling activities, and "hands-on" learning (CWLA Standards, 1986; Cahill, White, Lowe, and Jacobs, 1987; St. Louis' Parent/Infant Interaction Program; interviews with Griffin, 1995).

- Staff observation of parent/child interaction allows for the educational development of and communication between the instructor and the young parent. This allows the instructor to observe the young mother's/father's parenting practices and gives the instructor better insight into some of the issues that he/she needs help with (Oregon Child Development/Parenthood Education Program and Teen Parent Program Study, 1991; Cahill, White, Lowe, and Jacobs, 1987; interviews with Holman, Tate, 1995). Observation of parent/child interaction

typically is done during home visits, in group discussion sessions, or during involvement in a parent/infant lab or interaction program (Parent/Infant Interaction Program; Cahill et al., 1987; Green, 1994). It is important to have multiple methods to observe parent/child interaction as it is not always effective to do this during home visits (there may be too many distractions to the observer and the parent in the home setting) (interview with Tate, 1995).

- Peer support is fundamental to how adolescents become interested, retained and engaged in the learning process. "Informal kitchen talk" or informal opportunities for program participants to provide and receive support, ideas, information and advice play an important role in their learning, growing, and empowerment process (Dunst, 1995; Powell and Eisenstadt, 1988). It is particularly important to include some form of peer support because many adolescent parents lose connection with their friends and support systems once they start parenting. Peer support may be provided through group counseling sessions, peer mentor support networks, and/or through the use of peer program facilitators (Combs-Orme, 1993; CWLA, 1986; interviews with Siner, Warren, Holman, Bell, 1995).

- Recreational activities allow young parents to develop self-esteem, as well as decision-making skills. They expose teens to role models and professions that may be instrumental in their futures. Recreational activities also help teens to have fun with parenting and provide them with a release from the stresses of young parenthood (interviews with Bell, Siner, 1995; Solomon and Liefeld, 1994; CWLA Standards, 1986).

- The technique used to teach young men fathering may differ from the technique or methods used to teach mothering (Honig, 1980).

**Frequency/Duration**

While limited research has been conducted on the effects of the intensity of parenting education on parenting skills, professionals agree that it is an important component. The frequency of parent education sessions should be no less than once a week for the duration of a school year. These sessions or contacts can take on many forms — contacts with students may be through a combination of classroom instruction, support groups or meetings, one-on-one counseling, and home visitation.

- Frequency of parent education sessions differs by program. Examples include:

  - Parents as Teachers (PAT) has a home visit monthly and group meetings at the program site twice a month throughout the school year.

- MELD for Young Moms has a two-year program with sessions that run weekly for two hours;

- Oregon's Teen Parent Program meets five days a week and throughout the calendar year (during school year and in the summer). Most students are enrolled in Oregon's program for more than one year;

- adolescent parents in St. Louis' Parent/Infant Interaction Program's CRIB/Infant Toddler Day Care Center meet twice a week for the duration of the school year; and

- the National Black Child Development Institute's Parent Empowerment Project (PEP) contacts their students once a week in group and 2 to 3 times a month in home visits. Staff suggests that parenting education programs should last no less than six months (longer is better because longer work with teen parents builds trust and fosters growth).

## V. CASE MANAGEMENT/FAMILY SUPPORT

*Case management assures that community services, even though administered by varying service agencies and different service systems, are part of a coherent service plan for an individual client. (CWLA, 1986)*

Case management and service coordination is a vital part of any comprehensive service program for teenage parents and their children. The most recent research on Ohio's Learning, Earning and Parenting (LEAP) Program suggests that school-based case management (and child care) facilitates higher graduation rates and college enrollment for teen parents who have these services than those who do not (Long et al, 1996). Overall, the purpose of case management is to execute three vital program goals: coordination of services (child day care, preventive health care, prenatal care, etc.) to the young parent and his/her children; to build the young parent's skill, motivation, confidence, understanding, and capacity to be self-sufficient; and to build the strengths of the teen parent's nuclear and extended family.

With the emergence of the family support movement, some case managers working with teens have moved to concentrate their efforts on developing partnerships with families to help the teen parent achieve desired goals. This approach — one that is less paternalistic and more teen/family directed — has proven effective in working with adolescent parents. When we refer to case management in this document, we mean practice that incorporates family support principals.

To provide quality case management and family support services, attention must be paid to the core activities and/or functions provided by staff, building trusting relationships with teens, addressing and supporting whole family needs, providing culturally relevant services that build on family and community strengths, preparing staff for carrying out these tasks, and factors related to managing caseloads. These are discussed below.

### Goals and Functions of Case Management

Case management and family support services include:

- establishing contact or client identification and outreach;
- building a trusting relationship with the young parent and her family through working in partnership with the adolescent parent and his/her family;
- assessing the client's strengths and needs with an emphasis on strengths rather than on problems;

- helping the client identify, set and work toward obtaining goals through the design of a service plan and identification of needed resources with client and his/her family;

- monitoring and evaluating service delivery and modifying service plans when deemed necessary by the client and his/her family;

- acting as advocate for and with the client in the service network, the community, and his/her family (may occasionally conduct home, school, and social-agency visits with clients);

- enhancing the client's and his/her family's "system survival" skills by helping the client and members of her family to function as independently as possible and become skilled problem-solvers, through linking the client and family to needed services;

- establishing access to service delivery and developing productive working relationships within and outside of the service network;

- providing support and counseling with appropriate referrals (this includes one-on-one counseling, group counseling, and family mediation);

- conducting and attending in-service training, case conferences, and service network meetings to enhance knowledge of community resources and advancements in service delivery;

- following up with the client to see whether the teen parent obtained the service, and acting as mediator between the client and potential service providers; and

- evaluating with the client whether the agreed-upon activities and services were effective and whether personal goals were met.

- Case manager role descriptions are derived from recommendations and standards by California's Adolescent Family Life Program (AFLP); Brindis, Barth, & Loomis, 1987; Marks, 1995; Marzke, 1995; Smith, 1995; C-Stars Guidelines, 1992; CWLA, 1986; Roberts-DeGennaro, 1989; and interviews with Warren, Siner, and Bruner, 1995).

- Guiding principles of family support have been described by Weissbourd, 1990; Goetz, 1992; and Larner, 1995.

Not all functions of case management need to be carried out by a single individual. A team approach (consisting of professionals and non-professionals) that divides these functions among them may be used to provide case management services more efficiently.

- It may be more effective for case management functions to be provided through a team approach rather than through one manager. The C-Stars interprofessional case management model for at-risk adolescents is characterized by three organizational components: a case manager responsible for identifying at-risk adolescents, monitoring their service plan, advocating with service agencies on their behalf, and maintaining sustained contact with them; an interprofessional case management team responsible for collaboratively planning, accessing and delivering needed services; and a comprehensive community service network responsible for delivering specific services or items that go beyond the case management team's expertise or resources (i.e., clothing or medical examinations). The network also identifies ways to make service coordination more effective and efficient (Smith, 1992).

- An effective way to meet family needs is to look to people in the community as sources of support. These sources include, but are not limited to, family members, relatives, friends, neighbors, day-care centers, neighborhood and community organizations, churches and synagogues, recreation centers and YW/MCAs, family support programs, hospitals and community health centers, public health and social services departments, and early intervention and human services programs (Dunst, 1995).

- Agencies draw upon consultants for expertise and services that cannot be obtained through other agencies in the community. They use their knowledge and skills to facilitate the implementation of a comprehensive service plan. The team of consultants may consist of physicians, nurses, psychiatrists, teachers, health educators, psychologists, nutritionists, lawyers, vocational guidance and employment counselors, and members of the clergy. Consultants advise case managers and are sometimes asked to directly work with the young parent or family. The managers determine when services of a consultant are needed (CWLA, 1986).

**Building Trusting Relationships with Adolescent Parents**

Effective case management relies on strong, trusting relationships among the teen parent, his/her family and the case worker. To build strong relationships, efforts should be made to provide consistent, helpful assistance to teen parents in a respectful manner that acknowledges their growing independence.

- Case management for adolescent parents should be provided in a way that allows them to receive assistance and support without fear of being judged or stigmatized (Dunst, 1995).

- An important step to establishing trust between the case manager and the adolescent parent's family is case managers treating the young mom and her family with dignity and respect in non-judgmental ways (Dunst, 1995).

- The ability and effectiveness of each case manager will highly depend on that manager's communication style and personality. Case managers of teenage parents who allow their client to have a higher level of control over the choices made for them (mutuality communication style) are shown to have better relationships with their clients than those who don't allow their clients to have any control (paternalistic communication style) (interviews with O'Sullivan and Bruner, 1995).

- Teen parents often have multi-dimensional issues that may overwhelm them. Establishing a set of measurable and achievable goals allows the young parent to notice and appreciate the changes leading toward their goals. This can increase motivation for both the teen parent and the case manager (Kinney, Strand, Hagerup, & Bruner, 1994).

- Case managers must be consistent and trusting if they want to gain the trust and respect of their teen parent clients (teens watch everything you do and are very judgmental). The hardest thing to influence is the young mother's attitude. However, facilitators cannot influence her attitude and establish a bond if they are not consistent (interview with Tate, 1995).

- Research of the TAPP program in San Francisco identified factors that are important in developing good relationships with clients: formal and informal time spent together over an extended period; counselors' physical availability to the client so that he/she could link the client with concrete services; and the client's ability to follow through in obtaining the assistance arranged through TAPP case managers as evidenced by advocacy and support. Time availability was reported as the major barrier to establishing good relationships (Brindis et al., 1987).

**Family Support and Engagement**

Case managers must recognize the nuclear and extended family as having the most important influence on the young parent's life and should make efforts to include and engage it. Members of the family often closely assist the teen parent in raising his/her child and make up the base of his/her support system. The case manager should see the family as a potential resource and

take steps to build its strengths and address its needs at both individual and systems levels. Particular emphasis may be placed on the role and support of grandparents (the teen's parent) as well as the teen parents' female siblings (to prevent additional teen pregnancies).

- Family engagement is a necessary part of case management for teen parents (Cahill, White, Lowe, and Jacobs, 1987; Solomon and Liefeld, 1994; interviews with Siner and Griffin, 1995).

- Research indicates that family participation is important for improving the outcomes of adolescent parenthood (Furstenberg and Crawford, 1978).

- Parents of adolescent parents (the grandparents of the child) may be uniquely involved in caring for the child, as they continue to have parental responsibilities or influence over the adolescent. Their involvement in counseling and in other social support services provided to the adolescent parents is thus critical, and may be a determining factor in the success of the service plan developed for the adolescent parent. Similarly, other extended family members who have close involvement with, or influence upon, the adolescent parents' choices should be involved in the provision of services. However, members of the young parents' families should be involved in counseling when it is agreeable to the young parent (CWLA, 1986).

- The process by which case managers address the needs of families who participate should be guided by the following principles: partnership (developing a relationship with the family based on equality and respect); empowerment (linking families to ongoing supports and promoting family ownership of the programs with which they are involved); cultural competence; provision of services to build parenting strength; and volunteerism (i.e., parents participate voluntarily) Family Resource Coalition, 1991.

- Case mangers have the means to empower families by giving them the ability to serve as resources (or peer support) to each other, to participate in program decisions and governance, and to advocate for themselves in the community (Larner, 1995).

- Case managers who interact with teenage fathers should carefully monitor their own tendency to characterize these young men in terms of society's stereotypes. Many of these fathers do want to become involved and desire to share the responsibility for their child (Barret and Robinson, 1982).

- Voluntary family participation, or seeking of support and information, should be seen as a sign of family strength, not problems (Larner, 1995).

- Family support challenges the notions that "healthy" families do not need support and "sick" families unable to care for themselves depend on support. Lack of income is not synonymous with lack of family integrity or strength (Dunst, 1995). Every parent, (whether adolescent or adult), has strengths ranging from interpersonal skills to cognitive or physical capability (Zigler and Black, 1989; Dunst, 1995).

**Culturally Relevant Case Management/Family Support**

Efforts to engage teen parents and their extended families should build on their cultural and familial strengths. Positive and practical program practices that contribute to cultural sensitivity may include use of paraprofessionals from the community, bilingual staffing, and parental participation in policy and decision-making (Williams, 1987, Dunst, 1995).

- The key to gaining the trust of the family is developing a relationship between the program and the family that is based on equality and respect. Programs impart equality by recruiting staff or case managers who share the background and values of participating families, providing training that emphasizes the familial and cultural context of child development, and building the case manager's skills in communication and cross-cultural cooperation (Family Resource Coalition, 1991; Larner, 1995). This allows the case manager to be viewed by families as peers (with whom they can develop a bond or positive relationship).

- Affirming, promoting and strengthening the cultural diversity of families is a necessary step in gaining their confidence, respect, and participation (Dunst, Trivette, Starnes, Hamby, & Gordon, 1993; Solomon & Liefeld, 1994).

- An understanding and appreciation of the ecologies of culturally diverse people, knowledge of the meaning of community among people who differ in their cultural backgrounds, awareness of those to whom culturally diverse people look as sources of support, and an understanding of a group's beliefs about child rearing and developmental expectations are all necessary (though not sufficient) conditions for engaging in practices that affirm and strengthen cultural competence (Green, 1982; Kavanaugh and Kennedy, 1992; Laosa, 1980; Lynch and Hanson, 1992; and Dunst, 1995).

- When the case managers neither speak the same language as the young mom's family nor understand their values and priorities, it is easy for her family to feel they are losing control over her socialization (which is the opposite of the goal of family support) (Larner; 1995). One way to provide cultural sensitivity is by hiring managers who represent the community and cultures served (Larner, 1995).

**Case Manager/Family Support Worker Qualifications**

It is preferable to employ case managers with bachelor's degrees in education, social work, health services or a related field. Relevant work experience (i.e., working with families, familiarity with the community and its resources, working with adolescent parents) carries equal weight, however, and can compensate when candidates lack subject-specific education.

Case managers should possess the following attributes and orientations:

- a non-judgmental attitude;
- a nurturing personality;
- energy for meeting new people and building new relationships;
- positive life experiences in caring for children;
- ability to maintain objectivity;
- general trust in others;
- a strong commitment to job goals;
- willingness to work nontraditional hours;
- flexibility in addressing new situations;
- tolerance for ambiguity and for autonomy;
- patience;
- willingness to confront others, when needed; and
- a good sense of humor.

These qualities should be looked for in all workers, as they relate to both the effectiveness of the specialist in performing the job and their satisfaction with the type of work they will be expected to do (Bruner, Berryhill and Lambert, 1992).

- Qualification recommendations regarding education are from the National Center for Children in Poverty (Marzke, 1995); interview with Bruner, 1995.

- Research suggests that case managers often do not have prior case manager experience, but do have college degrees in these fields (Smith, 1995; Marzke, 1995).

- Qualifications and attributes of the case manager/family support worker are from Bruner, Berryhill and Lambert, 1992.

- Research suggests that the best case managers are those who are over 35 and have teen children of their own (interview with O'Sullivan, 1995).

- Research suggests that effective case managers display certain skills and attitudes including the ability to engage clients in a trusting working relationship, to express appropriate empathy, and to facilitate learning of a broad range of skills (Kinney, Strand, Hagerup, and Bruner, 1994).

**Case Manager Development and Training**

Case managers working with pregnant and parenting teens must have specific knowledge or experience related to adolescent development. Regardless of the model of case management used (health, social work, etc.), a keen understanding of teens is important. In addition, case managers should be familiar with issues related to: teen pregnancy and parenting; methods of providing family support; child development; child abuse and neglect; health education; family planning; and community resources. They should also have good counseling and communication skills, the ability to work with families and the ability to work with other agencies in the coordination of multiple health, education, and social services.

Specifically, case managers should be trained in how to emphasize client (parenting teen and her family) strengths rather than client pathology, how to use client strengths and resources in problem solving, how to work together with clients to create very specific, short-term, measurable goals for treatment, and how to take a holistic approach to designing service plans (so that plans encompass a broad range of factors while still tailored to meet the needs and goals of the client).

- Training specifications from Kinney, et al., 1994; Smith, 1995; and interviews with Siner and Tate, 1995.

- Teen parents are generally a poor, low-educated, and abused population who have had a bad school experience — the case manager must, therefore, understand how to counsel and provide appropriate services to young parents with these issues as well as issues associated with teen parenting and adolescent development

(interview with Warren, 1994; CWLA, 1986; Musick, 1995; interviews with Maynard and Siner, 1995).

- Health education training is important for those case managers who work in maternal and child health settings. They should be familiar with common health problems of pregnant women and infants, understand their nutritional needs, and be able to suggest strategies for promoting their personal health management (Brindis, Barth, & Loomis, 1987).

- To help identify training needs, case managers should undergo performance reviews. Such reviews might include self reports or self assessments, client satisfaction reports, a supervisory assessment, and standardized testing to measure specific skills, knowledge, and affective competencies. Other training might include various in-services (on-going workshops, colloquiums, seminars) and university course work (C-Stars Guidelines, 1992).

- Case managers often are not prepared for their duties or the responsibilities associated with their position prior to accepting the position. Therefore, new managers may be required to shadow senior-level case managers or supervisors (Marzke, 1995).

**Caseload Size**

Professionals and researchers in the field of services for pregnant and parenting teens suggest a caseload size ranging from 15 to 30 cases per manager. However, family support professionals suggest that 10 to 15 cases may be more appropriate for programs that emphasize broad family engagement. Overall, the number of cases a professional can take on greatly depends on the needs of individual clients and their families and the supports available to the manager.

- The optimal caseload size is 15 to 20 cases/manager (30+ cases are considered too high by the field for the adolescent parent population and 30+ has also been shown to be too much for managers when they are serving whole families) (CWLA, 1986; interviews with Maynard and Bruner, 1995).

- The appropriate size will depend on the number of supports available to the manager (i.e., a tracking system would allow a manager to be able to handle more cases; support teams, etc.) (interview with Maynard, 1995).

## Contact Frequency

Frequency of case manager/client contact depends to some extent on the needs of the client. At a minimum, case managers should make face-to-face contact with each client once a month. However, some clients (those with intense needs) will need and should receive more contact than others.

- Program policy regarding contact frequency is highly variable. Specific program examples include:
  - California's AFLP requires case managers to maintain or attempt to maintain contact monthly;
  - New York's Teenage Services Act (TASA) requires managers to see clients at least twice each month; and
  - Pennsylvania's Education Leading to Employment and Career Training (ELECT) requires weekly contact for the first two weeks and bi-weekly contact thereafter.

## VI. FLEXIBLE, QUALITY EDUCATIONAL PROGRAMMING

*Pregnant and parenting teenagers account for a sizable and growing proportion of the population served by public schools. Twelve percent of all women aged 15 to 19 become pregnant each year and more than half of all teen pregnancies result in childbirth. (The Alan Guttmacher Institute, 1994)*

*Unfortunately, pregnant and parenting teens face significant barriers to academic achievement, largely because traditional school environments often conflict with the competing demands of pregnancy and child rearing. (Brake, 1995)*

One of the major goals of school-based programs for teen parents is to facilitate the long-term self-sufficiency of young families. As a result, facilitating the receipt of a high school diploma (or a GED) is a critical interim outcome that these programs must achieve. Of utmost importance is that adolescents have access to school-based or linked services — those of the kind outlined in this document — that can assist them in their efforts to succeed in school. In addition to links to services, schools must provide quality, flexible educational programs and environments that are conducive to their success. This often calls for changes at the school level and the identification of staff in schools who are responsible for the success of young families.

### School Policies and Practices

Schools should create and enforce policies and practices that encourage and create ways for pregnant and parenting teens to remain in school and complete their high school education. Key policies include flexible scheduling and crediting policies (award of partial credits, competency-based education), flexible attendance policies (to ensure that events such as morning sickness, pediatric appointments, pre- and postnatal appointments, and lack of child care are valid excuses for tardiness or absence) and ensuring educational continuity (i.e., offering homebound instruction and summer programming).

- Recommendations for the above guideline are from the Legislative Budget and Finance Committee Report, 1994; Earle, 1990; Brake, 1995.

- To avoid dropping out of school, pregnant and parenting students need flexibility in their class schedules that accommodates the physical demands of pregnancy, medical and social service appointments and parenting responsibilities. Allowing pregnant and parenting students who have social service and medical appointments or child care problems to report to school late, have home tutoring, or have partial schedules can mean the difference between their graduation and failure (Legislative Budget and Finance Committee, 1994; Brake, 1995).

- School districts and community service providers should coordinate service delivery to pregnant and parenting teens. On-site service delivery has been found to be very effective at linking adolescent parents to vital services. However, if

schools are not able to provide services on-site, they should develop a partnership with health departments, social services, employment and training institutions and non-profit community-based organizations (Brake, 1995).

- Flexible crediting (awarding credits based on mastery of the subject rather than instructional time), can be particularly helpful in averting a parenting student who missed only a few weeks of school from having to repeat her courses (Legislative Budget and Finance Committee, 1994; Sipe, Batten, Stephens and Wolf, 1994).

- Arranging partial schedules such as supplementing a lighter day-time course schedule with evening, weekend or summer classes enables students to complete the school's requirements at a manageable pace and gives students more flexibility if child care or health problems occur (Earle, 1990).

- Flexible attendance policies are essential to enable pregnant and parenting students to continue in their classes. This may include counting such students as constructively present who submit make-up work for classes missed because of a sick child or problems with child care. It can also include allowing such students to begin the school day later (then coordinating with local health providers to arrange early morning appointments), allowing them extra time to walk to and from classes, and giving bathroom passes if requested (Brake, 1995).

- Ensuring that there are strategies to facilitate educational continuity is key to the success of any initiative for pregnant and parenting students. These are strategies that keep the parenting student connected to the school system during and after her pregnancy. They include offering homebound instruction or providing homework and some instructional assistance to parenting students who are not physically able to come to school (Legislative Budget and Finance Committee, 1994).

- The development of summer programs provides an additional opportunity to accumulate credits. When available, students can use summer courses to move toward graduation by making up for courses missed or failed during the regular school year. An advantage for some students who are behind grade is the opportunity to "catch up," at least partially, in a short, but intensive session (Sipe, Batten, Stephens and Wolf, 1994).

**Appointing a Pregnant and Parenting Teen Advocate**

Given the complexities of keeping pregnant and parenting teens in school, one person in each target school should be designated as an "advocate" responsible for this population. These staff will have several responsibilities including but not limited to identifying and recruiting students

into the program, identifying their needs, explaining options for pursuing a high school diploma or GED, linking them to case management services, monitoring educational progress and attendance and serving as the liaison and advocate for this population with others in the school district (teachers, administrators) and the broader community.

- Pregnant and parenting students are still largely "invisible" in schools. A common institutional response is to quietly encourage them to leave school. Therefore, having a person in the schools who is an advocate for the adolescent parent population, who examines whether school policies and practices hinder the educational success of the parenting student population, and who keeps track of these students' academic progress is vital to assuring that individual pregnant and parenting students receive the support they need to remain in school (Earle, 1990).

- Conducting student assessments, advising students on academic options and alternatives, and developing educational plans is key to keeping students informed about credit requirements and academic progress. It is important to remember that teenagers are not adults and often need reminders and help when trying something new or when they are in a situation that frightens them (and pregnancy and parenthood are replete with difficult and frightening challenges) (Earle, 1990).

- Given the complex needs and varying health circumstances of pregnant and parenting students, it will be necessary at times to negotiate with teachers to get exam schedules changed or to get temporary leniency granted for students experiencing exceptional difficulty with their new situation (Earle, 1990). There may be cases where effectively doing this will require advocates to work on ridding teacher bias against pregnant and parenting students. Teachers and other adults working with these teens must help them acquire an education, rather than preaching the immorality of teen pregnancy (Brake, 1995).

- It is critical that the advocate be visible in the building all day, every day. This allows pregnant and parenting students to view this person as regularly accessible and available to them. It also improves the faculty's awareness of the issues affecting pregnant and parenting students in their school (Earle, 1990).

- Advocates act as bridges between students and school staff and between schools and communities. Schools should seek advocates who are visible; who have the ability to negotiate and communicate effectively with teachers, administrators, and community agencies; and who have a non-judgmental attitude, patience, and belief in the students (Earle, 1990).

## VII. FATHER INVOLVEMENT SERVICES AND SUPPORTS

*Children benefit from warm and nurturing relationships with men, and men are most likely to develop these sorts of relationships in environments which value, support, and encourage them. As a kind of shorthand, we call such settings "father-friendly environments." (Levine, Murphy, and Wilson, 1993)*

A significant challenge that school-based programs for pregnant and parenting adolescents face is providing supports to fathers. According to the Alan Guttmacher Institute, two thirds of the babies born to teenage girls are fathered by adult males. This is particularly challenging to a school-based program seeking ways to increase father involvement, because older fathers are not in school.

However, many fathers (or current male partners), whether of school-age or older, who wish to become involved in their child's life often face barriers and biases that inhibit them. If fathers feel unwanted or unwelcome in a family service setting, are unemployed (which often results in feelings of shame and embarrassment), have poor communication with their child's mother, or feel incompetent in their fathering role, they tend to be less involved. Programs should not equate absence with not caring. Studies on low-income non-custodial parents, such as the large-scale longitudinal study of Project Fair Share by the Manpower Demonstration Research Corporation, suggests that these fathers do not abandon their children — they see their children and participate in some key childrearing decisions (Bloom and Sherwood, 1994; Levine and Pitt, 1995).

School-based programs serving pregnant and parenting teens can adopt policies, outreach strategies and support services to facilitate relationships between fathers and their children and to assist fathers and their parenting responsibilities.

### Program Policy

Given the benefits of father involvement on a child's development, programs should institute policies to serve and support fathers or other current male partners. Although programs should take special circumstances into account (i.e., if the mother objects to the father's involvement), they should guard against practices and policies, often unintentional, that block involvement from those fathers who want to be supportive and nurturing of their child and the mother.

- Research investigating father-infant relationships suggests that a baby's interaction with its father significantly contributes to its intellectual and social development. Research has shown that: 1) babies who are nourished by their father's love and intimate responsive care will become well attached to their fathers and under normal circumstances will prefer paternal and maternal company equally; 2) fathers do seem to have their own special way of interacting with their infants. They engage in more vigorous types of play, in contrast to the more reciprocal vocalizations games mothers tend to play. Both activities are equally important

to the child's positive development; 3) through the variety of maternal and paternal touch, play and vocal patterns, infants learn better to deal with differing patterns of adult interaction, expectancies and styles; 4) if fathers admire their daughters and have a nurturing relationship with them, girls will relate well to boys and men during their teenage and adult years; 5) nurturing, warm fathers who are models of generosity, sympathy and compassion and value altruism tend to have sons exhibiting the same behavior (Honig, 1980).

- Recent studies have shown that when fathers provide at least 40 percent of the within-family care, their preschoolers show increased cognitive competence as well as more empathy and less sex-stereotyped beliefs (Levine, Murphy and Wilson, 1993).

- Studies also show having the father present, even sporadically, can decrease stress on a teen mother and help make her a better parent (Cox and Bithaney, 1995).

- Research suggests that when the father has been involved in his baby's everyday physical care during their first two months of life, the child tends to be more socially responsive and to disintegrate less in the face of distressing situations. The father's nurturing and care helps the infant to learn that a person can care for him or her and yet differ from the mother in smell, size, strength, sound, appearance, and handling style (Pruett, 1996).

**Outreach to Fathers**

Program staff should assume that all men can be reached and want to be involved with their children. Staff should, therefore, take practical steps to encourage and increase father involvement in their programs.

- Rather than assuming and accepting that men will not be involved in their children's lives, professionals should expect and encourage it (Levine and Pitt, 1995). This has proven to be true in prenatal outreach to low-income non-custodial fathers (Honig and Pfannenstiel, 1991), in working with teenage fathers in school settings (Freiman, 1994) and in working with fathers of all backgrounds in both preschool and school settings (Levine, Murphy, and Wilson, 1993; McBride, 1989).

- Creating "father-friendly environments" is a necessary step in making programs more receptive to men. Many fathers have come to see the systems in which they are involved (courts, child support system) as the enemy rather than sources of help (Simms and Sandell, 1996). Therefore it is important that any family-oriented program counter this potentially negative perception by establishing

environments that are respectful and supportive of the different fathers they hope to attract. This may mean having men on staff, displaying photos of men with children throughout the program's publications, adjusting center and class hours to accommodate (overtime) work schedules, and training staff to interact with fathers in respectful, non-judgmental ways (Wallace McLaughlin, Father Resource Program; and Gloria Rodriquez, Avance, found in Levine and Pitt, 1995).

- Whenever possible, invite men to parent meetings, and all family activities. Also creating opportunities for men to plan and carry out activities with their children is an effective program technique to attract and maintain father involvement (focus on creating opportunities that may be of special interest to men — fix up day, sports day) (Stan Seiderman, Fairfax-San Anselmo Children's Center found in Levine and Pitt, 1995).

- List the father on the enrollment form, include his contact information on program rosters and include him in all program mailings, newsletters, flyers, etc. (Stan Seiderman, Fairfax-San Anselmo Children's Center, found in Levine and Pitt, 1995).

- Research suggests that there are certain moments in the life cycle where fathers appear to be especially "reachable." Childbirth consistently stands out as the most opportune time. Entry into preschool is another particularly reachable moment. The passage of adolescence is a third reachable moment (Levine and Pitt, 1995).

**Specific Supports for Teenage Fathers**

Teen fathers should have access to the same types of supports as teen mothers. Particular attention might be paid to providing peer support, skills development, parenting education and potentially mediation services (joint counseling).

- As with older fathers, it is critical that adolescent fathers are provided with opportunities for peer support and peer exchange (Levine and Pitt, 1995). Opportunities for peer support are particularly important for adolescent fathers who find that the role of father involves decisions about the baby and separation from the peer group that adolescent fathers have difficulty coping with (Bryan, 1988).

- Teen fathers in particular will need skill development support and jobs assistance. Studies have shown that teenage fathers typically remain involved throughout the pregnancy if included early on (Robinson, 1988; Robinson, 1987). Studies have also shown that these young fathers plan to provide financial support and

participate in child care (Barrett and Robinson, 1982, Fry and Trifiletti, 1983; Redmond, 1985; Westney, Cole and Munford, 1986; Bryan, 1988). However, when the normal venues to obtain work are unavailable or inaccessible, many fathers — particularly young fathers with few skills and few years of schooling — either avoid the responsibility of supporting their children or often turn to informal economies (e.g., unrecorded and untaxed work) (Vivian Gadsden, 1996).

- Teenage fathers particularly need family planning education. Studies have shown that these young fathers often are uninformed about sex and sexuality (Bryan, 1988; Barrett and Robinson 1982; Brown, 1983; and Finkel and Finkel, 1975). Studies have also shown that teenage fathers do not use contraception or use it inconsistently (Alan Guttmacher Institute, 1982; Barrett and Robinson, 1982; Bryan, 1988). Activities that may help at-risk teen boys defer parenting decisions include ones that promote high self-esteem, teach greater responsibility for personal actions, and provide sex-role education (Pirog-Good, 1995). (Also see Prenatal Care and Family Planning section.)

- Fatherhood education is a critical service component for programs addressing the needs of young fathers. Adolescent fathers have a difficult time adjusting to fatherhood. Studies have shown adolescent fathers to have difficulty coping with knowledge of pregnancy and show signs of clinical depression or stress (Elster and Panzarine, 1983; Fry and Triflett, 1983; Vaz, Smolen and Miller, 1983; Westney, Cole and Munford, 1986; Bryan, 1988). Studies have also shown teen fathers to have role conflict over being both an adolescent and a father (Elster and Panzarine, 1983; Fry and Triflett, 1983; Robinson and Barrett, 1985; Bryan, 1988). Young fathers also tend to have more unrealistic expectations for child development and hold more traditional views of male-female roles (i.e., women's place is in the home) than young men who defer parenting until age 20 or later (Bryan, 1988; Pirog-Good, 1995. Also see Parenting Education section).

- Establishing mediation services may be a necessary step in achieving a quality co-parenting environment for the child. Programs need to acknowledge and address the lack of fathers' involvement that often stems from adversarial relationships between fathers and mothers, and from the lack of mediating skills on the part of both fathers and mothers (Levine and Pitt, 1995). The quality of communication between mothers and fathers is often a key determinant to the quality of the fathers' involvement: good communication with the mother means more frequent contact with the child and higher payment of child support (Ahrons and Miller, 1993; Levine and Pitt, 1995).

## RESOURCE ORGANIZATIONS TO ENHANCE KEY PROGRAM ELEMENTS AND SUPPORTIVE SERVICES

Readers may find the following organizations helpful in their efforts to strengthen school-based and/or linked services for teen parents and their children. Resources referred to in each category were used by CAPD for expertise in that particular category.[1]

### Chapter I: Child Care

Child Care Law Center
22 2nd Street, 5th Floor
San Francisco, CA 94105
Tel: 415/495-5498
Fax: 415/495-6734

Child Welfare League of America
440 First Street NW, Suite 310
Washington, DC 20001-2085
Tel: 202/638-2952
Fax: 202/638-4004

Children's Defense Fund
25 E Street NW
Washington, DC 20001
Tel: 202/662-3652

Family Resource Coalition
200 South Michigan Ave., Suite 1520
Chicago, IL 60604
Tel: 312/341-0900
Fax: 312/341-9361

Far West Laboratory for Educational Research and Development
730 Harrison Street
San Francisco, CA 94107-1242
Tel: 415/565-3000

[1] These organizations may have additional expertise in other subject areas.

National Black Child Development Institute
1023 Fifteenth Street NW, Suite 600
Washington, DC 20005
Tel: 202/387-1281 or 1/800/556-2234

National Center for Clinical Infant Programs
ZERO TO THREE
2000 14th Street North, Suite 380
Arlington, Virginia 22201
Tel: 703/528-4300
Fax: 703/528-6848

National Center for Children in Poverty
154 Haven Avenue
New York, NY 10032
Tel: 212/927-8793
Fax: 212/927-9162

National Head Start Association
201 North Union Street, Suite 320
Alexandria, VA 22314
Tel: 703/739-0875

**Chapter II: Prenatal Care and Reproductive Health**

The American College of Obstetrics and Gynecologists
409 12th Street SW
Washington, DC 20024
Tel: 202/638-5577

Child Welfare League of America
440 First Street NW, Suite 310
Washington, DC 20001-2085
Tel: 202/638-2952
Fax: 202/638-4004

National Center for Clinical Infant Programs
ZERO TO THREE
2000 14th Street North, Suite 380
Arlington, Virginia 22201
Tel: 703/528-4300
Fax: 703/528-6848

## Chapter III: Preventive Health Care for Children

The American Academy of Pediatrics
141 NW Point Blvd.
Elk Grove Village, IL 60007
Tel: 847/228-5005
Fax: 847/228-5097

Child Welfare League of America
440 First Street NW, Suite 310
Washington, DC 20001-2085
Tel: 202/638-2952
Fax: 202/638-4004

Children's Defense Fund
25 E Street NW
Washington, DC 20001
Tel: 202/662-3652

National Black Child Development Institute
1023 Fifteenth Street NW, Suite 600
Washington, DC 20005
Tel: 202/387-1281 or 1/800/556-2234

National Center for Clinical Infant Programs
ZERO TO THREE
2000 14th Street North, Suite 380
Arlington, Virginia 22201
Tel: 703/528-4300
Fax: 703/528-6848

## Chapter IV: Parenting Education

Academy for Educational Development, Inc.
The Support Center for Educational Equity for Young Mothers
100 Fifth Avenue, 2nd Floor
New York, NY 10011
Tel: 212/243-1110
Fax: 212/627-0407

Child Welfare League of America
440 First Street NW, Suite 310
Washington, DC 20001-2085
Tel: 202/638-2952
Fax: 202/638-4004

Far West Laboratory for Educational Research and Development
730 Harrison Street
San Francisco, CA 94107-1242
Tel: 415/565-3000

MELD for Teen Parents
123 North 3rd Street, Suite 507
Minneapolis, MN 55401
Tel: 612/332-7563

National Black Child Development Institute
1023 Fifteenth Street NW, Suite 600
Washington, DC 20005
Tel: 202/387-1281 or 1/800/556-2234

National Center for Children in Poverty
154 Haven Avenue
New York, NY 10032
Tel: 212/927-8793
Fax: 212/927-9162

National Head Start Association
201 North Union Street, Suite 320
Alexandria, VA 22314
Tel: 703/739-0875

Parents As Teachers National Center, Inc.
10176 Corporate Square Drive, Suite 230
St. Louis, Missouri 63132
Tel: 314/432-4330
Fax: 314/432-8963

**Chapter V: Case Management/Family Support**

Child Welfare League of America
440 First Street NW, Suite 310
Washington, DC 20001-2085
Tel: 202/638-2952
Fax: 202/638-4004

Child and Family Policy Center
Fleming Building, Suite 1021
218 Sixth Avenue
Des Moines, IA 50309
Tel: 515/280-9027

Council of Chief State School Officers
One Massachusetts Ave. NW, Suite 700
Washington, DC 20001-1431
Tel: 202/408-5505

Family Resource Coalition
200 South Michigan Ave., Suite 1520
Chicago, IL 60604
Tel: 312/341-0900
Fax: 312/341-9361

Far West Laboratory for Educational Research and Development*
730 Harrison Street
San Francisco, CA 94107-1242
Tel: 415/565-3000

METIS Associates*
80 Broad Street
New York, NY 10004
Tel: 212/425-8833
Fax: 212/480-2176

National Black Child Development Institute
1023 Fifteenth Street NW, Suite 600
Washington, DC 20005
Tel: 202/387-1281 or 1/800/556-2234

National Center for Children in Poverty
154 Haven Avenue
New York, NY 10032
Tel: 212/927-8793
Fax: 212/927-9162

## Chapter VI: Flexible, Quality Educational Programming

Academy for Educational Development, Inc.
The Support Center for Educational Equity for Young Mothers
100 Fifth Avenue, 2nd Floor
New York, NY 10011
Tel: 212/243-1110
Fax: 212/627-0407

Council of Chief State School Officers
One Massachusetts Ave. NW, Suite 700
Washington, DC 20001-1431
Tel: 202/408-5505

National Women's Law Center
11 Dupont Circle NW, Suite 800
Washington, DC 20036

National Association of State Boards of Education
1012 Cameron Street
Alexandria, Virginia 22314
Tel: 703/684-4000

*These two organizations may be helpful in developing case management information systems.

## Chapter VII: Father Involvement Services and Supports

Families and Work Institute
330 Seventh Avenue
New York, NY 10001
Tel: 212/465-2044

Family Resource Coalition
200 South Michigan Ave., Suite 1520
Chicago, IL 60604
Tel: 312/341-0900
Fax: 312/341-9361

National Organization on Adolescent Pregnancy, Parenting and Prevention, Inc.
4421-A East-West Highway
Bethesda, MD 20814
Tel: 301/913-0378
Fax: 301/913-0380

## RESOURCE PUBLICATIONS

Readers may find the following publications helpful to their efforts to strengthen and enhance supportive services for pregnant and parenting teenagers.


A Stitch in Time: Helping Young Mothers Complete High School. E.A. McGee, S. Blank. Washington, DC.: Academy for Educational Development. 1989.

Affirming Children's Roots: Cultural and Linguistic Diversity in Early Care and Education. H. Chang, L. Sakai. San Francisco: California Tomorrow Publication. 1993.

Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. M. Green (ed.). Arlington, VA: National Center for Education in Maternal and Child Health. 1994.

Child Welfare League of America Standards for Services for Pregnant Adolescents and Young Parents (revised edition). Child Welfare League of America, Inc. Washington, DC: Library of Congress. 1986.

Developing Individualized Family Support Plans: A Training Manual. T. Bennett, B.V. Lingerfelt, D.E. Nelson. Cambridge, MA: Brookline Books. 1990.

Healthy Young Children: A Manual for Programs. Administration for Children, Youth, and Families, American Academy of Pediatrics, Division of Maternal and Child Health, U.S. Department of Health and Human Services, Georgetown University Child Development Center, Massachusetts Department of Public Health, and the National Association for the Education of Young Children. Washington, DC: 1995.

In School Together: School-based Child Care Serving Student Mothers. M. Cahill, J.L. White, D. Lowe, L. Jacobs. New York, NY: Academy for Educational Development, School Services Division. 1987.

Key Characteristics and Features of Community-Based Family Support Programs. C. Dunst. Chicago, IL: Family Resource Coalition. 1995.

Learning to Work Together: How Education and Welfare Agencies Can Coordinate Schooling/Training of AFDC Teen Parents. Center for Law and Social Policy. Washington, D.C. 1994.

New Expectations: Community Strategies for Responsible Fatherhood. J. A. Levine, E.W. Pitt. New York, NY: Families and Work Institute. 1995.

School-Based Programs for Adolescent Parents and their Young Children: Overcoming Barriers and Challenges to Implementing Comprehensive School-Based Services. C. Sipe, S. Batten et al. Center for Assessment and Policy Development. Bala Cynwyd, PA. 1994.

Standards for Data Exchange and Case Management Information Systems in Support of Comprehensive Integrated School-Linked Services. San Francisco, CA: Far West Laboratory. March 1994.

Together We Can: A Guide for Crafting a Profamily System of Education and Human Services. A.I. Melaville, M.J. Blank, G. Asayesh. Washington DC: U.S. Department of Education and U.S. Department of Health and Human Services. 1993.

## BIBLIOGRAPHY


Aboud F. "Children and Prejudice." New York: Basil Blackwell. 1988.

Achatz M., MacAllum C. *Young Unwed Fathers: Report from the Field.* Public/Private Ventures. Philadelphia, 1994.

Adams D. "Engaging Teen Fathers Into Prenatal Care: From Exclusion to Inclusion." In *Presentation Abstracts: 1995 NOAPPP Annual Conference.* Maryland: National Organization on Adolescent Pregnancy, Parenting and Prevention, 1995.

Administration for Children, Youth, and Families, American Academy of Pediatrics, Division of Maternal and Child Health, U.S. Department of Health and Human Services, Georgetown University Child Development Center, Massachusetts Department of Public Health, and the National Association for the Education of Young Children. *Healthy Young Children: A Manual For Programs.* Washington, DC: 1995.

Ahrons C.R., Miller B.R. "The Effects of the Postdivorce Relationship on Paternal Involvement: A Longitudinal Analysis." American Journal of Orthopsychiatry, 1993; 63:441-450.

Alan Guttmacher Institute. *Sex and America's Teenagers.* New York. 1994.

Allen J.P., Philliber S., Hoggson N. "School-Based Prevention of Teenage Pregnancy and School Dropout: Process Evaluation of the National Replication of the Teen Outreach Program." American Journal of Community Psychology, 1990.

American College of Obstetricians and Gynecologists. *Standards for Obstetric-Gynecologic Services.* 7th edition. Washington, DC: American College of Obstetricians and Gynecologists, 1989.

American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care.* Elk Grove Village, IL: American Academy of Pediatrics, 1995.

Anderson C.W., et al. "Attachment to Substitute Caregivers as a Function of Center Quality and Caregiver Involvement." *Child Development,* 1981; 52: 53-61.

Barret R.L., Robinson B.E. "A Descriptive Study of Teenage Expectant Fathers." Family Relations, 1982; 31:349-351.

Barret R.L., Robinson B.E. "Teenage Fathers: Neglected Too Long." Social Work, 1982; 27 (6): 484-488.

Belsky J., Miller B. "Adolescent Fatherhood in the Context of the Transition to Parenthood." In A.B. Elster and M.E. Lamb (eds). *Adolescent Fatherhood.* Hillsdale, NJ: Lawrence Erlbaum Associates, 1995, pp.107-122.

Bennett T., Lingerfelt B.V., Nelson D.E. *Developing Individualized Family Support Plans: A Training Manual.* Cambridge, MA: Brookline Books, 1990.

Bloom D. V. et al. Interim Findings on a Welfare Initiative to Improve School Attendance Among Teenage Parents. New York, NY: Manpower Demonstration Research Corporation, 1993.

Bloom D., K. Sherwood. *Matching Opportunities to Obligations: Lessons for Child Support Reform from the Parents' Fair Share Pilot Phase.* New York, NY: Manpower Demonstration Research Corporation, 1994.

Brake D. *Goals 2000 and Pregnant and Parenting Teens: Making Education Reform Attainable for Everyone.* National Women's Law Center in collaboration with the Council of Chief State School Officers and the National Association of State Boards of Education. March 1995.

Brindis C., Barth R.P., Loomis A.B. "Continuous Counseling: Case Management with Teenage Parents." *Social Casework: The Journal of Contemporary Social Work.* 1987; 68(3): 164-172.

Brown S.V. "The Commitment and Concerns of Black Adolescent Parents." Social Work Research and Abstracts, 1983; 19:27-34.

Bruner C., Berryhill, M. Lambert M. *Making Welfare Work: A Family Approach.* Des Moines, IA: Child and Family Policy Center, 1992.

Cahill M., White J.L., Lowe D., Jacobs L. *In School Together: School-Based Child Care Serving Student Mothers.* New York, NY: Academy for Educational Development, School Services Division, 1987.

Cataldo C. *Infant and Toddler Programs: A Guide to Very Early Childhood Education.* Addison-Wesley Publishing, 1983.

Center for the Study and Teaching of At-Risk Students. *C-Stars Guidelines.* Seattle, WA. December 1992.

Chang H., Sakai L. *Affirming Children's Roots: Cultural and Linguistic Diversity in Early Care and Education.* San Francisco: California Tomorrow Publication, 1993.

Child Development/Parenthood Education Program and Teen Parent Program. Churchill High School, Eugene, Oregon, Program Study, August 1991.

Child Welfare League of America, Inc. *Child Welfare League of America Standards for Services for Pregnant Adolescents and Young Parents (revised edition).* Washington, DC: Library of Congress, 1986.

Children and Youth Funding Report. Silver Spring, MD: CD Publications, 1995.

Clark-Stewart K.A. "Predicting Child Development from Child Care Forms and Features: The Chicago Study." *Quality in Child Care: What Does Research Tell Us?* D.A. Phillips, ed. Washington, D.C.: National Association for Education of Young Children, 1987, pp.21-42.

Combs-Orme T. "Health Effects of Adolescent Pregnancy: Implications for Social Workers." Families in Society: *Journal of Contemporary Human Services,* June 1993: 344-354.

Comer J. "Racism and the Education of Young Children." *Teachers College Record,* 1989: 352-362.

Cost, Quality and Child Outcomes Study Team. *Cost, Quality, and Child Outcomes in Child Care Centers, Public Report.* Denver: Economics Department, University of Colorado, 1995.

Cox J., Bithoney W. "Fathers of Children Born to Adolescent Mothers: Predictors of Contact With Their Children At Two Years." Archives of Pediatric and Adolescent Medicine, Sept. 1995.

Cummings E.M. "Caregiver Stability and Day Care." *Developmental Psychology.* 1980: 31-37.

Cummins J. "Empowering Minority Students: A Framework for Intervention." *Harvard Education Review.* 1986: 18-36.

Danziger S.K. Radin N. "Absent Does Not Equal Uninvolved: Predictors of Fathering in Teen Mother Families." Journal of Marriage and the Family, 1990; 52(3): 636-642.

Daykin D., Eu H., Zimmerman E. "Teenage Pregnancy: Current Issues in New York." *Policy Research Series.* New York, NY: United Way of New York City, May 1994.

Department of Health Services, Maternal and Child Health Branch. *Adolescent Family Life Program Standards. Sacramento,* CA. March 1993.

Dobkin P.L., Tremblay R.E., Desmaraisgervais L., Depelteau L. "Is Having an Alcoholic Father Hazardous for Children's Physical Health?" *Addiction*, 1994; 89:1619-1623.

Dunst C.J., Trivette C.M., Starnes A.L., Hamby D.W., Gordon N.J . *Building and Evaluating Family Support Initiatives: A National Study of Programs for Persons with Developmental Disabilities.* Baltimore, MD: Paul H. Brooks, 1993.

Dunst C. *Key Characteristics and Features of Community-Based Family Support Programs.* Chicago, IL: Family Resource Coalition, 1995.

Earle J. *Counselor/Advocates: Keeping Pregnant and Parenting Teens in School.* Alexander, VA: National Association of State Boards of Education, 1990.

Edwards S. "A Rational Approach to Teenager Pregnancy Prevention. Changing the Contraceptive Behavior of Sexually Active Teens. A Framework for Discussion." Baltimore, MD: The Annie E. Casey Foundation, 1991.

Elster A.B., Panzarine S. "Unwed Teenage Fathers: Emotional and Health Educational Needs." Journal of Adolescent Health Care, 1980; 1:116-120.

Espinosa Michael. "Effects of Poor Nutrition on Development in Early Childhood." *Translating Research into Practice: Implications for Serving Families with Young Children.* The Second National Head Start Conference, Summary of Proceedings. Administration for Children Youth and Families, 1993.

Family Resource Coalition. *Training in Family Support: Towards a Conceptual Framework.* A report from A Wingspread Conference. Chicago, IL: Family Resource Coalition, October 1991.

Far West Laboratories. *Ten Keys to Culturally Sensitive Child Care Programs for Infants and Toddlers.* (Video) San Francisco, CA.

Finkel M., Finkel D. "Sexual and Contraceptive Knowledge: Attitudes and Behavior of Male Adolescents." Family Planning Perspectives, 1975; 7:256-260.

Flinn Foundation. *School Programs for Pregnant and Parenting Teenagers: Results of an Arizona Evaluation.* Phoenix, AZ, January 1994.

Fosburg S. "Family Day Care in the United States: National Day Care Home Study." Vol 1, Summary of Findings. Office of Human Development Services. DHHS Publication No. (OHDS) 80-30282. Washington, DC: U.S. Department of Health and Human Services, 1981.

Freiman B.B. "Children of Divorced Parents: Action Steps for the Counselor to Involve Fathers." Elementary School Guidance and Counseling, 1982; 28:197-205.

Fry P.S., Trifiletti R.J. "Teenage Fathers: An Exploration of their Developmental Needs and Anxieties and the Implications for Clinical-Social Intervention Services." Journal of Psychiatric Treatment and Evaluation, 1983; 5:219-227.

Furstenberg F.F., Crawford A. "Family Support." *Family Planning Perspectives,* 1978; 10:322-336.

Furstenberg F.F., Jr., Sherwood K.E, Sullivan M.L. *Caring and Paying: What Fathers and Mothers Say About Child Support.* New York, NY: Manpower Demonstration Research Corporation, 1992.

Gadsden V. "Fathers and Families: Building a Framework for Research, Practice, and Policy." Family Resource Coalition Report, 1996; 15(1): 18-20.

Galinsky E., Howes C., Kontos S. "The Family Child Care Training Study: Highlights of findings." Families and Work Institute, New York, 1995.

*Programs to Strengthen Families: A Resource Guide,* K. Goetz, third ed. Chicago, IL: Family Resource Coalition, 1992.

*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* M. Green, ed. Arlington, VA: National Center for Education in Maternal and Child Health, 1994.

Green J. *Cultural Awareness in the Human Services.* Englewood Cliffs, NJ: Prentice Hall, 1982.

Greenfield P., Lave J. "The Cognitive Aspects of Informal Education." In: *Cultural Perspectives on Child Development,* D. Wagner, H. Stevenson, eds. San Francisco, CA, W.H. Freeman and Co., 1982; pp. 181-207.

Greenspan S.I., Meisels S. and the ZERO TO THREE Work Group on Developmental Assessment. *Toward A New Vision for the Developmental Assessment of Infants and Young Children.* ZERO TO THREE/National Center for Clinical Infant Programs' Eighth Biennial National Training Institute, Washington, DC, December 1993.

Harrison G., Piette B. "Bilingual Mothers in Wales and the Language of their Children." *Social Science Monographs 6.* Board of Celtic Studies, University of Wales. Cardiff, Wales: University of Wales Press, 1981.

Hayes C., Palmer J. Zaslow M. *Who Cares for America's Children? Child Care Policy for the 1990s.* Washington, DC: National Research Council, 1990.

Holloway S.D., Reichhart-Erickson M. "The Relationship of Day-Care Quality to Children's Free Play Behavior and Social Problem Solving Skills." *Early Childhood Research Quarterly,* 3: 39-54.

Howes C. "Caregiver Behavior and Conditions of Caregiving." *Journal of Applied Developmental Psychology,* 1983; 4:99-107.

Honig A.S. "The Importance of Fathering." *Dimensions,* 1980; 9:33-38.

Honig A.S., Pfannenstiel A.E. *Difficulties In Reaching Low-Income New Fathers: Issues and Cases.* 65th Annual Meeting of the American Orthopsychiatric Association (1988, San Francisco, CA). Early Child Development and Care, 1991; 77:115-125.

Howes C., Rubenstein J. "Determinants of Toddler's Experiences in Daycare: Age of Entry and Quality of Setting." *Child Care Quarterly,* 1985; 14:140-151.

Howes C., et al. "Attachment and Child Care: Relationships with Mother and Caregiver." *Early Childhood Research Quarterly,* 1988; 3:403-416.

Howes C. "Relations Between Early Child Care and Schooling." *Developmental Psychology.* Pp. 53-57, 1988; 24:53-57.

Hughs M.E., Furstenberg F.F, Teitler J.O. "The Impacts of an Increase in Family Planning Services on the Teenage Population of Philadelphia." Family Planning Perspectives, 27: 1995.

Kinney J., et al. *Beyond the Buzzwords: Key Principles in Effective Frontline Practice.* Working paper by National Center for Service Integration and the National Resource Center for Family Support Programs, 1994.

Kavanaugh K., Kennedy P. *Promoting Cultural Diversity.* Newbury Park, CA: Sage Publications, 1992.

Kirby D., et al. "School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness." Public Health Reports, 109: pg. 339-361.

Klerman L.V., Horwitz S.M. "Reducing the Adverse Consequences of Adolescent Pregnancy and Parenting: The Role of Service Program" In: S.M. Coupey and L.V. Klerman (eds.), *Adolescent Medicine: State of the Art Reviews.* Philadelphia, PA: Hanley & Belfus, Inc. June 1992; 299-316.

Kontos S., Fiene R. "Child Care Quality, Compliance with Regulations, and Children's Development: The Pennsylvania Study." In: D.A. Phillips, ed., *Quality in Child Care: What Does Research Tell Us?* Washington, DC: National Association for the Education of Young Children, 1987; pp. 57-80.

Laosa L. "Maternal Teaching Strategies in Chicano and Anglo-American Families: The Influence of Culture and Education on Maternal Behavior." *Child Development*, 1980; 51: 759-765.

Larner M. *Linking Family Support and Early Childhood Programs: Issues, Experiences, Opportunities.* Chicago, IL: Family Resource Coalition, 1995.

Legislative Budget and Finance Committee. *Commonwealth Programs and Initiatives for Pregnant and Parenting Teens.* Harrisburg, PA. April 1994.

Levine J.A., Murphy D.T., Wilson S. *Getting Men Involved: Strategies for Early Childhood Programs.* New York, NY: Scholastic Inc., 1993.

Levine J.A., Pitt E.W. *New Expectations: Community Strategies for Responsible Fatherhood.* New York, NY: Families and Work Institute, 1995.

Long D., et al. *LEAP: Three Year Impacts of Ohio's Welfare Initiative to Improve School Attendance Among Teenage Parents.* New York, NY: Manpower Demonstration Research Corporation, April 1996.

Lynch E., Hanson M. (Eds.) *Developing Cross-Cultural Competence: A Guide for Working with Young Children.* Baltimore, MD: Brookes Publishing Co., 1992.

Marks E.L. *Managing Case Managers: Case Management in Service Integration.* New York, NY: National Center for Children in Poverty, July 1995.

Marks E.L. *Working with Clients: Case Management in Service Integration.* New York, NY: National Center for Children in Poverty, July 1995.

Marzke C. *Preparation, Staff Development, and Supervision of Case Managers.* New York, NY: National Center for Children in Poverty, July 1995.

McBride B.A. "Educators Can Promote Involvement of Fathers." *Education Digest*, 1994; 55(3): 43-45.

McCartney K. "Effect of Quality of Day Care Environment on Children's Language Development." *Developmental Psychology*, 1984; 20:244-260.

Miller B.C., Moore K.A . "Adolescent Sexual Behavior, Pregnancy, and Parenting: Research through the 1980s." *Journal of Marriage and the Family*, November 1990; 1025-1044.

Miller S.H. *A Select Review of Past and Current Evaluations of the Parents As Teachers Program.* St. Louis, MO: Parents As Teachers National Center, June 1995.

Musick J. "On Hidden Reasons Teens Have Babies." *The Children's Beat.* 1995; 3(1): 3-4.

Nagel H., Worobey J. "Nutrition and Behavioral Style in Pre-school-Aged Children." *Translating Research into Practice: Implications for Serving Families with Young Children. The Second National Head Start Conference, Summary of Proceedings.* Administration for Children, Youth and Families, 1993.

Needleman H.L., et al. "The Long-Term Effects of Exposure to Low Doses of Lead in Childhood." *New England Journal of Medicine,* 1990; 322(2): 83-88.

Olds D.L., et al. "Improving the Life-Course Development of Socially Disadvantaged Mothers: A Randomized Trial of Nurse Home Visitation." *American Journal of Public Health,* 1988; 78:1436-1445.

Oregon Child Development/Parenthood Education Program and Teen Parent Program Study, 1991.

Parent/Infant Interaction Program Materials. Department of Curriculum and Programs, St. Louis Public Schools. St. Louis, MO. 1993.

Peebles D.M., Hambry K.F. *Manual of Policies and Procedures for Comprehensive Case Management.* CA: Adolescent Family Life Program, 1993.

Peterson S., Brindis C. "Adolescent Pregnancy Prevention: Effective Strategies." National Adolescent Health Information Center, University of California, San Francisco, 1995.

Pirog-Good M.A. "The Family Background and Attitudes of Teen Fathers." *Youth and Society,* 1995; 26(3): 351-376.

Powell D.R., Eisenstadt J. "Informal and Formal Conversation in Parent Discussion Groups: An Observational Study." *Family Relations,* 1988; 37:166-170.

Pruett K.D. "Child Development: The Difference a Dad Makes." *Family Resource Coalition Report,* 1996; 15(1): 8-10.

Redmond M.A. "Attitudes of Adolescent Males Toward Adolescent Pregnancy and Fatherhood." *Family Relations,* 1985; 34: 337-341.

Richman J. "Men's Experiences of Pregnancy and Childbirth." In L. McKee and M. O'Brien, eds. *The Father Figure.* London: Tavistoch Publications, 1982; pp. 89-104.

Roberts-DeGennaro M. "Developing Case Management as a Practice Model. In N. Cervera and L. Videka-Sherman (eds.). *Working with Pregnant and Parenting Teenage Clients.* Milwaukee, WI: Family Service America and Albany, NY: Rockefeller College Press. 1989; pp. 39-46.

Robinson B.E. "Teenage Pregnancy from the Father's Perspective." In N. Cervera and L. Videka-Sherman (eds.). *Working with Pregnant and Parenting Teenage Clients.* Milwaukee, WI: Family Service America and Albany, NY: Rockefeller College Press. 1989; pp. 171-179.

Robinson B.E., Barrett R.L. "Teenage Fathers." *Psychology Today,* 1985; 19: 66-70.

Robinson B.E. *Teenage Fathers.* Lexington, MA: Lexington Books, 1988.

Roopnarine J.L., Ahmeduzzaman M. "Puerto Rican Fathers' Involvement with their Preschool-Age Children." *Hispanic Journal of Behavioral Sciences,* 1993;' 15(1): 96-107.

Rosenthal M.L. "Social Policy and Its Effect on the Daily Experiences of Infants and Toddlers in Family Cay Care in Israel." The Hebrew University, Jerusalem. Draft 1988.

Royce J.M., Darlington R.B., Murray H.W. "Pooled Analyses: Findings Across Studies." In *Consortium for Longitudinal Studies, As the Twig is Bent...*Lasting Effects of Preschool Programs. Hillsdale, NJ: 1983; pp. 441-460.

Ruopp R., et al. "Children at the Center: Final Results of the National Day Care Study." Boston: Abt Associates, 1979.

Sable M.R., et al. "Differentiating the Barriers to Adequate Prenatal Care in Missouri." *Public Health Reports.* 1987-1988; 105:549-555.

Sachs A. "What About Male Responsibility?" *World Watch,* 1994; 7(2): 12-19.

Sander J.H., Rosen J.L. "Teenage Fathers: Working with the Neglected Partner in Adolescent Childbearing." *Family Planning,* 1987; 19(3): 107-110.

Schorr L., Schorr D. *Within Our Reach: Breaking the Cycle of Disadvantage.* Anchor Books: New York, NY; 1988.

Schweinhart L.J., Weikart D.P., Larner M.B. "Consequences of Three Preschool Curriculum Models Through Age 15." *Early Childhood Research Quarterly,* 1986; 1: 15-45.

Simms D., Sandell E. "How Programs Are Advocating for Father-Friendly Systems." *Family Resource Coalition Report,* 1996; 15(1): 7.

Sipe C., et al. *School-Based Programs for Adolescent Parents and their Young Children: Overcoming Barriers and Challenges to Implementing Comprehensive School-Based Services.* Center for Assessment and Policy Development, Bala Cynwyd, PA, 1994.

Siren U. *Minority Language Transmission In Early Childhood: Parent Intention and Language Use.* Institute of International Education. Sweden: Stockholm University, 1991.

Smith A.J. "School-Based Case Management: An Integrated Service Model for Early Intervention with Potential Dropouts." A Series of Solutions and Strategies. Clemson, SC: National Dropout Prevention Center at Clemson University, September 1995.

Solomon R., Liefeld C.P. *Effectiveness of a Family Support Center Approach to Teen Pregnancy: Re-Pregnancy and School Drop-out Rates.* Pittsburgh, PA, May 1994.

Spencer M.B., Kim S.R., Marshall S. "Double Stratification and Psychological Risk: Adaptational Processes and School Achievement of Black Children." *Journal of Negro Education*, 1987; 56:77-87.

St. Louis Public Schools. *Parent/Infant Interaction Program.* (Packet). Department of Curriculum and Programs Division of Pupil Personnel Services, 1994-1995.

Suwalsky J.T.D., et al. "Continuity of Substitute Care in Relation to Infant-Mother Attachment." Paper presented at the convention of the American Psychological Association, Washington, DC, 1986.

Tepp A.V. Divorced Fathers: "Predictors of Continued Paternal Involvement." *American Journal of Psychiatry*, 1983; 140(11): 1465-1469.

Trussell J. "Teenage Pregnancy in the United States." *Family Planning Perspectives*, 1988; 262-272.

U.S. Department of Health and Human Services. Office of the Secretary. *Healthy Kids: Improving Health Care for Infants and Children.* Washington, DC, 1992.

Vaughn E.E., Grove F.L., Egeland B. "The Relationship Between Out-of-Home Care and the Quality of Infant-Mother Attachment in an Economically Disadvantaged Population." *Child Development*, 1980; 51: 1203-1214.

Vaz R., Smolen P., Miller C. "Adolescent Pregnancy: Involvement of the Male Partner." *Journal of Adolescent Health Care*, 1983; 4:246-250.

Weissbourd B. *Families as Nurturing Systems: Support Across the Life Span.* D. Unger and D. Powell, 1990.

Westney O.E., Cole O.J., Mumford T.L. "Adolescent Unwed Prospective Fathers: Readiness for Fatherhood and Behaviors Toward the Mother and the Expected Infant." *Adolescence*, 1986; 21: 901-911.

Williams K. Cultural Diversity In Family Support: Black Families. In S. Kagan, D. Powell, B. Weissbourd, and E. Zigler (eds.), *America's Family Support Programs*, New Haven, CT: Yale University Press, 1987; pp. 295-307.

Winter L., Breckenmaker L.C. "Tailoring Family Planning Services to the Special Needs of Adolescents." *Family Planning Perspectives*, 1993; 23: 24-30.

Wong Fillmore L. "When Learning a Second Language Means Losing the First." *Early Childhood Research Quarterly*, 1991; 6: 323-346.

Wymelenberg S. "The Dilemma of Teenage Parenthood." *Science and Babies: Private Decisions, Public Dilemmas.* Washington. DC: National Academy Press, 1990.

Zigler E., Black K.B. "America's Family Support Movement: Strengths and Limitations." American Journal of Orthopsychiatry, 1989; 59: 6-19.

## INTERVIEWS CONDUCTED[2]

| | |
|---|---|
| Bell, Michelle | MELD for Teen Parents |
| Bobo, Lynson Moore | Council of Chief State School Officers |
| Burroughs, Kathryn | The Children's Council of San Francisco |
| Bruner, Charlie | Child and Family Policy Center |
| Gibson, Frankie | Head Start Bureau, HHS |
| Griffin, Abby | Zero to Three |
| Holman, Patty | Parents as Teachers |
| Horowitz, Ruth | University of Delaware |
| Maynard, Rebecca | University of Pennsylvania |
| Monroe, Norma | California Department of Education |
| O'Sullivan, Ann | University of Pennsylvania |
| Simpson-Brown, Ronda | California Department of Education |
| Siner, Sheila | Far West Laboratories |
| Tate, Costella | National Black Child Development Institute |
| Turner, Linda | Family Resource Coalition |
| Warren, Connie | Academy of Educational Development |
| Wessler, Judy | Children's Defense Fund |

[2]Interviews were conducted by CAPD October — December 1995, except for the interview with Simpson-Brown which occurred October 1996.

## PUBLICATIONS AVAILABLE FROM CAPD

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Building Capacity for System Reform. Susan A. Stephens, Sally A. Leiderman, Wendy C. Wolf and Patrick T. McCarthy. 1994. 53 pages. ($3.00).

An Introduction to Medicaid Managed Care. 21 pages (plus appendices).
Medicaid Coverage of Benefits, Providers and Service Settings. 39 pages (plus appendices).
Medicaid Eligibility for Pregnant Women and Children. 10 pages (plus appendices).
Each by Sara Rosenbaum and Roger Schwartz. February 1993. ($5.00 each).

A Framework for Developing an Effective Service Strategy (Working Draft). Charles Bruner, Judy Langford Carter, Wendy Deutelbaum, and Karen Kelley-Ariwoola. January 1993. 111 pages (plus appendices). ($10.00).

A Guide to Planning and Development, Stage 2: Development Planning. Sally A. Leiderman, Patrick T. McCarthy, Susan A. Stephens and Wendy C. Wolf. January 1993. 150 pages. (No charge for single copy; $10.00 for additional copies).

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Governance Options for The Children's Initiative: Making Systems Work. Elizabeth C. Reveal. 1991. 39 pages. (No charge for single copy; $5.00 for additional copies).

The Children's Initiative: Making Systems Work. A Design Document for the Pew Charitable Trusts. Sally A. Leiderman, Elizabeth C. Reveal, Ann Rosewater, Susan A. Stephens and Wendy C. Wolf. 1991. 128 pages. (No charge for single copy; $6.00 for additional copies).

### ADOLESCENT PARENTING

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Working with Teen Parents and Their Children: The Importance of School-Based Programs and Guidance for Child Care Professionals in the Field -- A Briefing Paper. 1996. Susan T. Batten. 14 pages. ($2 for single copy).

School-Based Programs for Adolescent Parents and Their Young Children: Community Assessment Workbook. Susan A. Stephens. 1996. (No charge for single copy; $3.00 for additional copies).

School-Based Programs for Adolescent Parents and Their Young Children: Overcoming Barriers and Challenges to Implementing Comprehensive School-Based Services. Cynthia L. Sipe and Susan T. Batten with Susan A. Stephens and Wendy C. Wolf. 1994. 112 pages. ($5.00).

Adolescent Pregnancy Prevention: What We Know and Next Steps -- A Briefing Paper. Susan A. Stephens and Sally A. Leiderman. 1994. 68 pages. (No charge for single copy; $5.00 for additional copies).

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## OTHER

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